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CLINICAL LECTURES.

POLYURIA OF INTERSTITIAL NE- PHRITIS.—DIABETES INSIPIDUS. —TUBERCULOSIS OF THE BOWELS.¹

BY JAMES B. WALKER, M. D.,

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Polyuria of Interstitial Nephritis.

Gentlemen: The first case I wish to show you this morning is a man, sixty years old. His parents both lived to about the age of ninety years. He is Irish by birth, and a sailor by occupation. His health has always been good. He denies any specific history, and has never had any sickness. Twelve

¹ Delivered at the Philadelphia Hospital.

years ago he suffered from an hemiplegic attack involving his whole right side, including his face. With this there was aphasia. He has never fully recovered from this attack. For the past six weeks he has had some cough and hemoptysis with some dyspnoea. With this there has been profuse expectoration; his sleep is disturbed; he has lost no flesh. This part of his history, however, has no reference to his actual trouble. He is suffering from polyuria. Here is a record running over a series of days, showing how much urine he has passed. On October 27, 1889, he passed 66 ounces, and from that time on it has varied up to 70 and 80 ounces. The character of his urine is as follows: On February 12, the urine contained no abundant sediment, but on microscopical examination, triple phosphates and some granular debris were found, also a trace of albumin; its reaction was faintly acid. In December it was alkaline in reaction, but with no albumin. On November 28, the specific gravity was 1.008,

triple phosphates and a trace of albumin were found, but no casts; the reaction was alkaline. On October 24, it contained no casts, but a trace of albumin, and a small amount of white sediment; the reaction was neutral. On September 13, hyaline and pale, granular casts were found, with some albumin; the reaction, acid and the specific gravity was 1.010. The first record was taken September 5, when the specific gravity was 1.010, and phosphates and hyaline casts were found, and a decided ring of albumin was produced by the acid test.

The present condition of the case is as follows: The amount of urine voided is greater than normal; it contains no albumin; the specific gravity is below normal. His temperature chart shows an occasional slight amount of fever. Most of the time since August, the amount of urine passed has been over 60 ounces a day. With this is a history of a slight hemiplegic attack involving the whole right side of the body. With such a history in a person 60 years of age, what is the diagnosis to be arrived at? There is no marked atheroma of the surface vessels, the tortuous temporal artery being the only change noticed in the vascular system. That he has fragile vessels, however, is shown by the fact that he has had one attack of hemiplegia.

What, now, is the cause of polyuria? There are two causes. The first of these is a high arterial tension, as seen in cases of interstitial nephritis; the other is a low local tension as seen in polyuria associated with diabetes insipidus where there is a loss of the watery constituents of the blood due to a want of vaso-motor tone in the kidneys, often from centric trouble. In such cases there is no albumin in the urine, which has a very low specific gravity, 1.003 to 1.005; and is associated with incessant thirst, rapid emaciation and dryness of the skin, but no atheromatous vascular changes. This condition is often transient and undergoes rapid improvement, in other cases it is persistent and untractable. Then we have polyuria in diabetes mellitis, where there is a large amount of urine with a high specific gravity, and loaded with sugar. There are other conditions in which it is found, as in acute alcoholism; and in amyloid degeneration of the kidney, where there is a tendency for the blood to leak through the hyaline and modified vascular walls in the kidney. But in the ordinary chronic conditions in which we find in-

creased urination, the condition is one of the three first mentioned.

This patient has had a polyuria since last August, passing nearly twice the normal amount of urine. This is a small amount to pass in diabetes, but it is a large amount in a case of ordinary Bright's disease. Formerly all cases of albuminuria were classified as Bright's disease, but now we recognize the existence of albuminuria from transient causes without any disease of the kidney. Bright's disease includes any alteration of the essential structures of the kidney. These structures are three in number. Thus we have the excretory system, comprising the kidney cells, the parenchyma of the organ. Then we have the vascular system, the vessels which carry the blood to these cells, whose debris constitutes the essential part of the secretion. The third structure is the connective tissue constituting the enclosing capsule. The enveloping capsules of the vessels, and the separating and uniting capsules of the tubules.

Inflammation of the first of these structures constitutes the so-called parenchymatous nephritis, that is, disease of the essential tissues of the organ. Thus pneumonia is a disease of the parenchyma of the lung, and acute yellow atrophy, of the parenchyma of the liver, so this is a disease of the parenchyma of the kidney. Tubular and desquamatic nephritis are synonymous with parenchymatous nephritis. The tendency to desquamation gives rise to the second name, and often there is but very little epithelium left in the tubes. It is also called catarrhal nephritis. This may run a course, pure and simple, with rapid destruction to life or restoration to perfect health.

Then we may have disease beginning in the blood-vessels. Amyloid degeneration is essentially a disease of the blood-vessels. It is seen also in the intestines, liver and spleen, always beginning in the vascular walls. The third form of the disease is where the connective tissue is involved in the inflammation primarily. Some say that we can only have tubular disease as a result of a primary disease of the connective tissue. Two of these forms are nearly always commingled, namely, disease of the tubules and of the capsule. Interstitial or granular nephritis and tubular nephritis are more or less always commingled, except in the rare acute condition I have mentioned above. The case before us presents an interstitial nephritis with a tubular nephritis in a slight degree.

Interstitial nephritis of long duration is absolutely incurable, but amenable to treatment, and the patient may be kept in a fair condition, death resulting from some intercurrent condition, such as uremia, or vascular changes elsewhere, inducing apoplexy. When a patient presents himself, and we find a trace of albumin present in the urine and persisting or recurring, but with no sign of dropsy, we may rest assured it is a case of interstitial nephritis. If we find a history of polyuria, with no dropsy, and no, or but little, albumin, and the urine of a low specific gravity, with a pulse of high tension or cardio-vascular degenerations, we may also set it down as being chiefly a case of interstitial nephritis. These constitute the large majority of cases of Bright's disease. To one case when the parenchyma is chiefly involved there are three to five where the connective tissue chiefly suffers.

The characteristics of this condition are an increased urination due to the influence exerted on the circulatory system by an imperfectly depurated blood. The increased arterial tension results in a polyuria. The kidneys are not doing their work, and some material is retained in the blood, uric acid perhaps, which raises the arterial tension by producing a spasm of the muscles of the arterioles at the termini of the arterial circulation. Hypertrophy of the left ventricle results from the stimulus to development caused by increased effort needed to open the aortic orifice. Many cases of atheroma of the vessels are induced by this condition of the vascular system. The tunica intima is first invaded; it becomes roughened, local clots are formed, emboli result; or partial rupture occurs with the formation of miliary aneurism; or larger aneurisms may be formed; or an actual rupture of the entire vessel takes place, with resulting hemiplegia. These cases are the most amenable to treatment of all the renal cases. We can assist them if we cannot cure them. Whenever albuminuria presents itself the case at once assumes a serious aspect; as this indicates a tubular nephritis in addition. A very small amount of albumin only is capable of changing the case into one of great gravity. If œdema is associated with this, it is probably due to amyloid disease, or to a late change in the interstitial cases.

It is favorable that the patient should void this large amount of urine, and no efforts should be made to stop it. It is well to give him Poland water or Apollinaris or other

medicated water in order to further depurate the blood. We thus favor this increased formation of urine.

Diabetes Insipidus.

The next case is one of polyuria also, in which, however, there is no albumin. It has recently arisen in a patient suffering from malaria. Here is a patient presenting attacks of chills associated with fever, especially in the afternoon, and at intervals periods of decided fever. Suddenly he develops polyuria. On February 7 he passed 160 ounces of urine in twelve hours. On Feb. 8, during twenty-four hours he passed 240 ounces. The following days the amounts passed were 180, 220 and 170 ounces. The specific gravity of the urine has been low, 1.004, 1.010, 1.007 and 1.004. The urine has a faint odor, is alkaline, contains no albumin nor sugar, and is almost colorless. Polyuria due to diabetes insipidus differs from polyuria arising from interstitial nephritis in the fact that it is acute and sudden and is usually a transient condition.

This other patient has polyuria also, due to diabetes insipidus. The specific gravity is low, 1.003 or less. It is generally lower than it is in interstitial nephritis. This patient has been suffering from malaria. This is one of the causes of diabetes insipidus. It may also be a cause of interstitial nephritis, however. His skin is not very dry; his tongue is pale, but not dry; he is very thirsty, especially at night. As regards treatment, in simple polyuria ergot has given the best results. We will place this man on from ten to twenty drops of the fluid extract three times a day.

Tuberculosis of the Bowels.

Last week I showed the class a case of disease of the alimentary tract, associated with a diarrhoea which had lasted over a long period. The patient was emaciated and phthisical-looking. His abdomen was slightly tympanitic over the small bowel, that is from the suprapubic region to the umbilicus. The disease had existed about ten months, with from four to nine movements of the bowels per day. Medicine arrested this a little, but had no permanent effect. On account of the fulness in the centre and lower portion of his abdomen we thought that the small bowel suffered most. There was tenderness over the entire abdomen, but especially in the centre. The case seemed to be one of

interitis. We considered the question of tuberculosis of the bowel, but as he had a fever chart with a normal morning temperature we laid aside this thought, but did not discard it altogether, merely not laying much stress upon it. The next day the man died. His abdomen swelled rapidly, and in it were found four quarts of fluid which was not all there when I showed him to you.

The entire alimentary tract from the stomach down was invaded with the disease. In the rectum were large surface ulcers and nodular patches. On the colon were a few ulcers at intervals of a few inches, from the size of a small pin-head up to that of a ten-cent piece, or greater. The salivary glands were not as extensively involved as in chronic dysentery. There was the same deep staining as seen in chronic inflammation of the bowels. In the transverse colon were three large ulcers extending down and into the muscular coat. From here there was no involvement of the colon to any extent until one ulcer was found above the cæcum, and two at the ileo-cæcal valve. The appendix was free at the extremity. The small bowel showed ulcerations all the way along its extent, and closer together than in the large bowel. Considerable hyperemia also existed here. These ulcers all had their long axis in a transverse direction. Their edges were thick and prominent, and surrounded by numbers of small miliary bodies. Numerous clusters of tubercles were found. The peritoneum was thickened and roughened. The valvulae conniventes were eroded and destroyed where ulcers existed.

This was a very interesting case, illustrating the condition which a week ago we were considering. One feature of the case should have led us to make a diagnosis of tuberculosis, and that was the persistency of the inflammation in the smaller bowel for so long a period. This should always lead us to suspect the presence of tuberculosis where hygienic and medicinal efforts for relief are unavailing.

—Sodium carminate for staining nervous tissues, en masse, in place of the usual borax carmine, alum carmine and Delafield's hæmatoxylin, is advocated by Dr. Geo. A. Piersol in the December, 1889, number of the *Microscopical Journal*. Dr. W. B. Canfield describes the microscopical analysis of urine in the same number of that journal.

REMOVAL OF UTERINE APPENDAGES.¹

BY E. E. MONTGOMERY, M. D.,

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Gentlemen: This woman is twenty-four years old, unmarried, and has had pain at her menstrual periods for some years, together with menorrhagia. Two months ago she began to suffer severe pain in her right side which she then thought was due to a prolapse of the uterus. Examination, however, does not disclose such a displacement, but the uterine appendages are inflamed, prolapsed and exceedingly tender. One tube is considerably enlarged, quite tortuous and at times gives her great agony. From this she has suffered for years in lifting, straining and violent movements. When we consider the inflammatory condition of these organs and their influence upon the general economy, it is not surprising to find such an individual living the life of an invalid. Both patient and general physician hesitate to accept an operation as the only method of relief; and various procedures have been suggested to provide escape from it. Of these, electricity is probably the most promising; but we cannot see how this agent even will be capable of restoring the functions of tubes which have occluded by lymph exudations which guard the peritoneal cavity from infection with an irritating fluid contained within the tubal sacs. It is difficult to believe that a restoration to normal condition, or even one approaching it, can be accomplished by such measures in a tube the seat of a hydro-, a hemato- or a pyo-salpinx. Therefore, while I thoroughly deprecate any rash or useless operations, yet, as these organs are already diseased beyond recovery, I feel that by their removal I am not uselessly mutilating my patient, but am merely relieving her of organs that are useless—and even worse than useless—painful and dangerous. A pus sac may open through the vagina; but, unless this be kept open, it will recur and bring on the symptoms by which it was previously accompanied. Consequently we do not hesitate to operate on this patient. Her bowels have been thor-

¹ Delivered at the Philadelphia Hospital.

oughly moved and thorough cleanliness has been obtained by washing with soap and water; especially over her abdomen and external genitalia. These parts are now again washed in a bichloride solution. I have the table, upon which are my instruments, close beside me, so that I can reach them as they lie in the pans, covered with plain hot water; and in this way save having to resort to the use of a middle man who might possibly prove a source of sepsis. I cut through the skin and superficial fascia, always trying to strike the linea alba. If, however, I do not cut down on this line, I do not fret about it. I next cut through the other fasciæ and peritoneum with probe-pointed scissors. Introducing two fingers into the wound, I feel for the fundus uteri as a landmark, and, passing outward to the left, a mass is felt which is closely adherent; indeed completely encapsulated. My fingers are passed over this and enucleation made from below upward. As it is brought out you see pus exuding from the Fallopian tube—a clear demonstration of its character and of the importance and necessity of the operation.

I use as small a ligature for the pedicle as will serve the purpose. The ovary and tube are cut away, and, finding that bleeding is securely prevented, the ligatures are cut short.

The opposite side is now investigated, and the right ovary and tube are found adherent and enlarged. Experience has demonstrated that where inflammatory trouble exists in one tube sufficient to require removal, the remaining one will sooner or later develop trouble that will necessitate a repetition of the operation. In the present instance the condition amply justifies removal of the second tube and ovary.

The peritoneal cavity is flushed out with simple hot water, to remove the blood which has oozed from the torn adhesions and to decrease the possibility of infection from the tube. The stitches are introduced through all the fasciæ of the abdomen, at about one quarter of an inch apart. They are then tied from below upward, care being taken that the wound surfaces shall be carefully approximated, and the parts antiseptically clean. The wound is dressed with: 1, iodoform and iodoform gauze; 2, dry bi-chloride cotton; 3, burnt cotton; 4, adhesive strips; and finally, 5, a crinoline binder, which is finer than flannel, and which is pinned from above downward with safety pins. The

pressure of this binder lessens the danger of venous oozing in the abdomen.

The patient is now put in bed, and hot bottles are put to her feet and around her. Later she will be given a limited supply of liquid food by the rectum. Nothing is to be administered by the mouth until the nausea caused by the ether and the handling of the ovaries has ceased. After the first forty-eight hours she will receive by the mouth some liquid food, among the varieties of which I am very partial to bovine. Avoid the use of morphine, unless the pain be very excruciating. It often has the result, by checking the secretions, of making the temperature go up. If, however, there is an elevation of temperature and signs of peritonitis, I generally give a saline cathartic, in order to deplete the blood-vessels and to clear out the alimentary tract. If there were many adhesions and much pus a drainage-tube should be used, taking care to place it in such position that the lowest portion of the peritoneum can be reached. If necessary, the cavity may be irrigated with hot water or a disinfecting solution every few hours.

In cases of extensive adhesions it is sometimes preferable to keep the abdominal cavity filled with a solution of boro-glyceride. With the cavity filled with the fluid the intestines do not lie in contact continuously, and consequently there is less danger of the formation of unfortunate adhesions. The torn, denuded peritoneum is renewed. This is accomplished by frequent irrigation, permitting the tube to remain filled with fluid.

COMMUNICATIONS.

PATHOLOGY OF TYPHOID FEVER.¹

BY CHARLES F. J. LEHLBACH, M. D.,
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Some questions relating to the causation of *typhoid fever* cannot be fully discussed without reference to the pathological anatomy of the disease and to some of the minute histological changes accompanying its progress. In fact these pathological changes stand in direct causative relation to the complexus of symptoms which makes

¹ From a paper read before the Newark, N. J., Medical Association.

up our conception of typhoid fever. On the other hand, the question of what causes these lesions, brings up at once the whole subject of their external cause. Without attempting to give a review of the various controversies that mark the progress of medicine in relation to this disease, it may be stated that typhoid fever, its symptoms and its lesions, are due to the presence of a poison in the system, a poison of a specific nature, which is either generated in the body itself, or introduced from without.

The external origin of the poison is, at present, generally conceded; although it is but fair to state, that up to a time approaching nearly the end of the past half of this century the view that the poison originated within the body was entertained by many eminent observers and medical philosophers.

The most characteristic lesion of typhoid fever consists in the changes in the lymphatic follicles, in the inflammatory enlargement and subsequent degeneration of the solitary glands and Peyer's patches or agminated glands.

To understand fully these changes and some of the influences which will hereafter be made, it may be worth while to glance for a moment at the histological relations of these glands. They are, in the first place, *absorbent* glands in contra-distinction to Brunner's glands and Lieberkühn's follicles, which are organs of secretion of the intestinal fluids. The structure of the solitary glandules and of those forming Peyer's patches is the same. According to Dalton, they have a close relation with the lymphatics of the intestine. The lymphatic vessels coming from the villi form a plexus in the substance of the mucous membrane, from which branches pass to the follicles and ramify over them, forming another plexus upon their investing capsule. Owing to the analogy in structure between these bodies and portions of the lymphatic glands, as well as to the fact that the lacteals from the neighborhood of Peyer's patches are more numerous than those from other points of the intestine, the closed follicles are generally regarded as belonging to the system of the lymphatic glands. They furnish no secretion to the intestinal cavity, but are connected in some way with the elaboration of the absorbed materials. Now the minute changes which take place in the course of the intestinal lesion in typhoid fever are as follows (Delafield & Prudden): "At first

the blood-vessels, around the follicles are dilated and congested, while the follicles are swollen, and the epithelium falls off. Then the follicles increase largely in size from a growth of new cells. The new cells are, in part, similar to the lymphoid cells, which normally compose the follicles, in part are large, rounded cells, some of which contain several nuclei. The production of new cells is not confined to the follicles, but extends also to the adjacent mucous membrane. In many cases also, little foci of the same cells are found in the muscular, sub-serous and serous coats. This increased number of cells compresses the blood-vessels and the parts become anemic. Soon the cells degenerate either by granular degeneration of individual cells, or by gangrene of part of a follicle. In either case the degenerated portion is eliminated into the intestine, and leaves an ulcer of which the floor and edges are infiltrated with cells. After this the cell-growth goes on, and the ulcer enlarges, or the cells are gradually replaced by connective tissue, and cicatrization follows." You will see phases of this process in the sketches of ulcers handed round, and the actual microscopic sections will be ready for your inspection later on.

In more severe types of the disease the enlargement of the follicles ends in ulceration. This takes place in two ways:

(a) The enlarged follicles often break down, and discharge into the intestine. In this way are formed small ulcers. These ulcers increase in size by the same softening process which gradually attacks their edges, and in this way ulcers of large size may be formed. The ulcers may extend outward only to the peritoneal coat, or they may involve the peritoneal coat also and perforate.

(b) In the severest forms of the disease, considerable portions of the enlarged patches slough, are detached and leave large ulcers with thick, overhanging edges. The slough may involve only the follicles or it may involve also the muscular and peritoneal coats. These ulcers also may afterwards increase in size, and several of them may be joined together. "If the patient recovers, the ulcers cicatrize, their edges become flattened, their floors are converted into connective tissue covered with cylindrical epithelium."

With this description of the process of the main lesion of severer forms of typhoid fever, we can readily understand and explain the various symptoms which it presents: the tympanitis, the meteorism, the gurgling

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round, the tenderness in the right iliac fossa and the peritonitis at times. But in milder forms these abdominal symptoms need not be so marked, and these are the cases which often give rise to doubt as to whether they are really typhoid or not. For—according to the same authors—“if the disease was mild and the enlargement of the follicles moderate, the enlargement gradually disappears and the follicles resume their normal appearance. In moderate enlargements, the retrograde processes affect first the follicles and leave the septa between them still swollen and prominent. This gives to the surface of a patch a reticulated appearance. After a time, however, the entire patch becomes flattened and uniform. . . . The solitary follicles, also, or the separate follicles of a patch soften, break down, and their contents are discharged with some attendant hemorrhage. This leaves a bluish-gray pigmentation in the situation of each follicle. This pigmentation may remain for years.”

Thus the cause of so much variation in the gravity of the symptoms of the disease may be readily understood, when we bear in mind the variation in the number of glands affected, the degree of their inflammation, and the succession of the process to rapid healing or to destructive ulceration. The not unfrequent, so-called relapses of the fever—as far as my experience goes—seem to be mainly due to, and to coincide with, the invasion of new glands, with a repetition of the intensity of symptoms.

Leaving the intestinal lesion in its causative relation to the symptoms of the disease, I will now refer to only one more of the pathological changes in the various organs—that of the spleen; and as I intend to draw some inferences therefrom relating to the external cause of typhoid fever, I here call attention to the anatomy of the spleen and its vascular arrangements.

“The spleen,” says Prudden, in his manual of Normal Histology, “although differing in many important and probably most essential particulars from the lymphatic glands, yet presents many striking analogies with them. Like them it presents on cross-section, to the naked eye, a fibrous envelope—the capsule—from which septa and trabeculae pass into the organ, enclosing irregular spaces. Here, also, we find the spaces between the septa followed with a soft substance presenting two distinct modes of arrangement; we find first, irregularly scattered through the organ, small grayish globular or elongated

structures, called Malpighian bodies, or follicles; and second, between these, filling up the remaining space between the trabeculae, a soft, red tissue called the pulp. Finally, blood-vessels.”

We must notice the fact that the splenic artery is remarkable for its large size in proportion to the size of the organ, and also for its tortuous course. “If,” says Prudden, “we carefully study the walls of the smaller arteries, we find that in certain parts they undergo a singular modification: at first the connective tissue sheath and the adventitia become very loose in texture, and their masses become filled with spheroidal cells, resembling lymph-cells—this is called lymphoid infiltration of the walls of the arteries; then we find that at certain points this infiltration becomes quite extensive, the intercellular substance assuming the character of reticular connective tissue; and thus distinct spheroidal or much elongated swellings are formed either around or at one side of the arteries—these are the splenic follicles or Malpighian bodies. The blood, after its exit from the fine arterial twigs on which the Malpighian bodies are found, passes, through the intervention of the capillaries, probably directly into the meshes of the pulp-cords; and after circulating here among the cells,—not in distinctly walled channels—it finally finds its way into the cavernous veins, whence it passes out of the organ through the large efferent veins at the hilus.”

Now the spleen in nearly every case of typhoid fever is enlarged. This enlargement begins soon after the commencement of the disease, increases rapidly until the third week, remaining stationary for a few days, and then diminishes. The organ is congested, of a dark-red color, and of firm consistence, while it is increasing in size. After it has reached its maximum size, its consistence becomes soft, and there is a considerable deposit of brown pigment. The enlargement appears to be due to the congestion, and to an increase of the normal elements of the spleen.

There is another anatomical fact in the vascular arrangement of the spleen to which I must allude for later reference. It is the arrangement of the splenic vein in its bearing to the relative rapidity of the flow of blood into the portal vein. It commences by five or six large branches, which return the blood from the substance of the organ. These, uniting, form the main trunk which, passing behind the upper border of the pan-

creas, and receiving gastric, pancreatic and other branches unites with the superior mesenteric vein at nearly a right angle, to form the portal vein. Hence the rapidity of the flow of blood is, in the first place, diminished by the angular meeting of these two currents; and, secondly, the rapidity of the flow is entirely uninfluenced by the direct suction force of the diastolic action of the heart as is the blood of the vena cava. The large inflow of blood, then, through the splenic artery, the largest branch of the coeliac axis, the second given off from the abdominal aorta, with its tortuous circulation through the organ, and its retarded outflow through the portal circulation, form conditions which may have an important bearing upon the presence, movement and elimination of a poison introduced into the blood.

The introduction of so much elementary matter is necessary to connect the links of subsequent argument. How is the poison of typhoid fever, which gives rise to the pathological changes characterizing the disease, introduced into the system? The evidence in the literature of the history of typhoid epidemics or endemics, and in the thousands of accumulated accounts of sporadic cases, is overwhelmingly demonstrative of the fact that the poison of typhoid fever—whatever it may be—is often introduced into the system by means of water used for drinking purposes. And we are not justified in assuming that this introduction, or the contamination of the water is only an accidental concurrence. Chemical examination has failed to discover the nature of the poison in drinking water to which cases of the disease have been clearly attributable. But, in all cases under my own observation, when everything pointed to the introduction of the poison through these means, an ordinary examination by simple tests showed the existence of chlorides and ammonia above what is admissible—a proof not only of contamination by organic decomposition, but a proof also of the greater probability of such water to favor the growth, development, or, at least, the viability of pathogenic germs accidentally introduced into it. "In many instances of infection through the water," says Flint, "it has been possible to show some communication or leakage between a well used for drinking purposes and a privy-vault, cesspool, sewer or drain. Instances of the introduction of the poison by means of milk have been numerous."

During the autumn of 1888 I was forcibly impressed with the possibility of the introduction of the typhoid fever germ in this manner. I was attending a young man, twenty-four years old, suffering with typhoid fever, at Elizabethport, N. J., near the Central R. R. Station. The ground is swampy, well-water is used exclusively by the people living in the street where my patient resided, and goats form part of the domestic household in nearly every family. Numerous cases of typhoid fever had occurred in the street, a number fatal.

Now, on inquiry as to how the dejections of the patients were disposed of, I was told that great care was taken not to contaminate the privies; but that the dejections were emptied and spread over the soil in the lots in the rear of the houses, to which the goats had free access, to pick their food. The germs may lie dormant there even during winter, because, as Prudden has demonstrated by his exhaustive researches, freezing does not kill the germs, and thus, with the thaw of spring and the new grass, the dormant microbes may be called into new life in the goats' intestines, be absorbed into the blood, and carried into the lacteal secretion, and thus keep up the vicious circle of organic poisoning.

My views in regard to the causation of typhoid fever by water contamination have been repeatedly expressed, and also my emphatic condemnation of the use of well-water in this or any other large city, and my firm belief, based upon observations in a practice of over thirty years, that our aqueduct water, derived from a large, quickly-flowing stream, constantly subject to the purifying influence of sunshine and aëration, never has been and never will be the cause of infection by pathogenic germs. I have now in my possession the history of thirty-one cases of typhoid fever treated during the autumn and winter of 1888-89, in the German Hospital, of this city, with names and residences, and this is the résumé: Of the total number—31—there were

Well-water exclusively,	23
Doubtful,	4
Aqueduct water exclusively,	3
Mixed,	1

I need not extend my remarks in this direction. If there is anything certain in the practice of medicine of to-day it is this, that the poison of typhoid fever is not generated in the body *de novo*, but that it is introduced

from without, that it may be introduced in various ways by food or drink, or careless and uncleanly handling of the dejecta of patients, and that it is certain, just to the point of absolute proof, that the poison consists of a germ to which the name *typhoid bacillus* has been given.

I shall leave the discussion and demonstration of the bacillus to more competent hands, but will conclude with a few remarks connecting the doctrine of the microbic cause of typhoid fever with some clinical and pathological facts. It is impossible for us, even after the circle of evidence in support of the bacillar origin of the disease shall have been positively proven to dive down the stomach of a patient and follow the invasion of the bacilli thence onward. But let us, with such light as we possess, follow them in our imagination. We have a patient who has been drinking well-water or ice-water containing the bacillus or the spores (?). His stomach secretion is acid and does not form a favorable settling-place for the microbe. The out-flow of gastric secretion prevents it from finding a lodgment, as do the secretions from the upper portion of the small intestines, including the pancreatic and biliary secretion. In addition, the current of capillary circulation in the mucous follicles here is outward, rather than inward. But as the bacillus passes down into the ileum and cæcum, the current begins to flow inward rather than outward. The patient perhaps has, by some indiscretion in diet, contracted a slight intestinal catarrh, some little local lesion by fruit seeds, or what not, sufficient to abrade or denude, here and there, the upper epithelial covering. The bacillus finds a lodgment in one or the other solitary or agminated gland, and under the most favorable surroundings begins to develop and multiply. Gland after gland becomes involved; and, as the multiplication of bacilli and their spores (?) goes on, the lymphatics become involved and the bacilli are carried on into the general circulation. Up the lymphatic vessels into the thoracic duct, up the vena cava into the heart, through the lungs back to the left side of the heart, into the general circulation, down the abdominal aorta a short distance, when the great current of a large arterial stream carries them through the splenic artery into the spleen. Or, instead of being taken up into the thoracic duct, part may have been carried through the mesenteric glands into the mesenteric veins, and thus

first through the portal circulation, there to encounter to some extent the germicidal effect of the bile, as those carried through the lungs are probably largely devitalized by the effect of oxygenation, but a portion are undoubtedly still carried on through the hepatic vein into the vena cava and onward as before until they reach the spleen.

The somewhat detailed allusion to the vascular arrangement of the spleen made above here finds its application. In the first three weeks of the invasion of the typhoid bacilli the spleen enlarges, swells up, sometimes to three or four times its natural size, undergoes a process of hyperplasia of its normal elements, and finally, with recovery, resumes its natural condition, leaving no trace of permanent lesions, except in rare instances. Is there a reason for this? Unfortunately the physiology of the spleen gives us no clue. Let us bear in mind these three facts: that the spleen is the receiver of a relatively large amount of blood which circulates in it with a great deal of sluggishness on account of the tortuosity of its arteries and glandular attachments; that in consequence of the arrangements of the veins and their connection with the portal system, this sluggishness of circulation is not counter-balanced, and lastly, that the spleen, as far as present investigations have resulted, is a favorite repository of the fever bacilli. Shall we look upon the splenic lesion then as simply accidental, or as one in the chain of reaction against the intruding microbes? With the clinical experiences in regard to other diseases of undoubted microbic origin—such as yellow fever, malarial fever, anthrax, etc., in all of which a similar enlargement of the spleen takes place, I have no hesitancy in saying that we have a right to attribute to this organ an active rôle in the series of processes of recovery from typhoid fever. The spleen, to use a homely illustration, is a sort of temporary guard-house, a prison for the transient confinement of the millions of invading poisonous tramps, where they may be either cleansed or starved to death, or experience a gradual jail-delivery, without an opportunity to overrun the commonwealth, and so are rendered comparatively harmless. The spleen I look upon as a trap, wherein the bacilli are caught.

Here speculation ceases and a new light dawns. The stellar worlds that Galileo dreamed of became visible to Herschel, and as the nebulae are resolved by the great

Lick refractor into individual starry worlds, so speculative philosophy in medicine must submit to the inevitable and yield the sceptre that it swayed for centuries to the new science: to culture tube and Abbé condenser.

EDUCATION IN AMERICA.

BY SAMUEL G. DIXON, M. D.,

PROFESSOR OF HYGIENE IN THE UNIVERSITY OF PENNSYLVANIA.

There is probably no more difficult problem to solve than that of education. It is claimed by some that we have brought the standard up to a higher level than, perhaps, any other country, excepting Germany. But in doing this, have we thoroughly comprehended and grasped the meaning of the word; or, in other words, have we realized all that is meant by it? We may have sent out from our universities, young men thoroughly equipped in their various branches of science or commercial training; able to take their places at the desk, in the laboratory, the law courts or the forum, or at the bedside. But in doing this, have we fulfilled our whole duty to them? I fear not. Something is lacking. What is it?

The answer comes back to us in an ominous form. The records of our criminal courts, the almost daily reports of absconding clerks and defaulting cashiers, physicians convicted of malpractice, physicians accused of improper conduct in the sick-room, men in positions of trust suddenly disappearing, who previously held a high place in their community, who ranked high in the Church and enjoyed the regard and esteem of their neighbors, all these instances furnish us with a sad reply. And yet these men went forth into the world thoroughly trained and competent to perform the duties of their respective callings. Their intellectual training was complete, but something was wanting. What was it? I think the answer simple. There was no moral stamina, and when the hour of temptation came, they simply succumbed and fell down like a house of cards.

That the danger is a great one to our community is not to be questioned—it is open and palpable. How can we counteract it or in other words, how can we with our educational system provide at one and

the same time for the moral and intellectual training of the mind? The latter is abundantly provided for, the former is very generally ignored. Home training and home influence are relied upon to afford what our universities fail to supply. These may be good, bad or indifferent, but if they are bad, there is nothing to put in their place.

The most critical period in the life of a boy is when the time comes to go to college or university. He has to rely much on his own resources; and, if his nature be weak and wavering, a hair's breadth may turn it for good or evil. The education of the mind begins at the cradle and ends with the grave. Mr. Gladstone, a few years ago, learned Italian in order to master Dante; but I believe the training of the moral faculties is practically ended at manhood. Impressions formed during childhood and adolescence are indelible, and I firmly believe that the moral impressions received during the first twenty years of a boy's life will ultimately guide him in after life. They may become strengthened and solidified as years go by, but they will not deviate much from the early path.

This brings me to the point I most strongly wish to urge, namely, the great necessity of a high moral tone among those whose duty it is to complete the educations of young men soon to enter into life. To educate we must strive to unfold the higher faculties of our natures; to succeed in this with others we must exhibit such virtues. The university or college student is naturally inclined to look upon his teacher as a model. It is an undeniable fact that tutors frequently indelibly stamp their characteristics upon their students. The leader of any educational institution should be qualified to instil those great principles of moral self-government which lie at the root of every well-regulated character.

In this connection we cannot but call to mind the example of Dr. D. Hayes Agnew, whose life and work will ever stand out as a beacon in the history of medical and moral education. Many of his students were his personal friends and their extraordinary attachment to him was owing to the great moral influence he exercised over them.

Moral and intellectual training must go together, hand in hand. The example must be real, and must consist in the highest performances of the duties of life. But there is a spurious imitation very prevalent, which palms itself off as the genuine thing, about

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which I would like to say a word before concluding. Let me illustrate my meaning. Our doctor comes to me and says: "My dear sir, you are killing yourself by excessive drinking, and unless you make up your mind to stop it, you will ruin your constitution and come to an early grave."

We think it over and arrive at the same conclusion and determine to give up drink in order to lengthen our days, and the better to enjoy life. We plume ourselves on having done a meritorious action and receive the congratulations of our friends with much self-complacency. Now if we come to analyze it, this is not a moral act in any sense of the word. We have acted not by the light of any principle of ethics, but simply from an interested motive and an instinct of self-preservation.

But if the doctor says "I earnestly want you to give up drinking, not only because it is impairing your mind and warping your moral nature, but also because it is inflicting a grievous injury on your wife and family, degrading your family name, and causing sorrow to those who love you." Then, if we decide to give up the evil habit, we are acting, not only on moral, but also on religious grounds, of the highest kind.

For the spurious morality we have no use—call it by its right name. It would send out into the world a breed of prigs, however highly cultivated. The real morality will give us a race of Christian gentlemen. It is this real morality that we must have among those entrusted to mold the minds of our young men.

Intellectual cultivation without a corresponding moral culture goes to increase the power of the possessor to execute the mandates of the Devil.

I have not space to pursue this important subject farther, but I trust I have said enough to show the vital importance of a high practical moral example by those connected with educational institutions and who have the oversight of young men and women about to take the first step into the perils and dangers of the world.

—By the light of bacteriological investigation, the problems of ventilation assume a new form, and in the ventilation of rooms we shall soon need to ask whether the greater danger lurks in the so-called impure air of such rooms, or in the germ-laden outside atmosphere which we admit as "pure."

PEROXIDE OF HYDROGEN.

BY CHARLES P. NOBLE, M. D.,

PHILADELPHIA.

The use of this agent in therapeutics by the profession in general has been limited, and the opinion expressed by many concerning its value has been uncertain, or certainly not laudatory. My own experience has convinced me that it is an agent of great value, hence this short communication. I was induced to use peroxide of hydrogen through the recommendation of an aurist who had employed it to cleanse the auditory canal. The first case in which I used it was one of syphilitic rupia. When first seen, the patient, a woman, was covered with sores and crusts, literally from the crown of her head to the soles of her feet. The physician preceding me—the eighth in attendance on the case—had used ointments as an external application. As a result, the woman was greasy from head to foot, her clothing and the bed being in like condition. It was during the heated term, and swarming flies completed as wretched a picture as I ever beheld. I was told that the patient could not be made to eat. And I could not wonder. Daily ablutions, with use of diluted peroxide of hydrogen, to clean the sores and to disintegrate the crusts, together with the application of subnitrate of bismuth as a drying powder, soon changed all this and the patient felt clean once more. This I am satisfied saved her life—she was at death's door—as the internal treatment employed by myself was doubtless the same as given by my predecessors. The sores healed kindly under this treatment with internal administration of ninety grains of iodide of potassium daily.

Since that time I have used freely the peroxide of hydrogen as a cleansing agent. I was especially pleased with its action in a case of fecal fistula, following the removal of a dermoid cyst of the ovary. This fistula was probably caused by the hair from the dermoid cyst having grown into the bowel. No fecal odor was noticed during the operation, but it appeared in the drainage-tube two days later. The amount of fecal discharge was small, but it, of course, infected the drainage-tube tract and excited pelvic peritonitis. The abdominal wall about the incision became brawny and slight sloughing resulted. The discharge was re-

moved from the tube with cotton, on the cotton forceps, and the tube and incision were cleaned with dilute peroxide of hydrogen several times daily. The patient—who was a brave girl—remarked that she had a soda-fountain inside her. And it was indeed remarkable to see the disintegrated discharges bubble out of the drainage-tube and incision. Corrosive sublimate solution was also used sparingly. By keeping the parts clean in this way, the fecal fistula closed after three weeks, and the incision healed excepting at the site of the drainage-tube. The sinus remaining gives no trouble and is fast closing up.

The peroxide has been equally satisfactory in disintegrating the pus in a number of cases of abscesses. No one can appreciate the difference in the cleanliness obtained by washing an abscess with water and that by the peroxide. I have recently used it to irrigate a pleural sac, after evacuating a pyo-pneumo-thorax by a free incision. In three days the stench from the discharge in this case was entirely controlled.

The peroxide had been used pure and dilute—as dilute as one part to six. I feel sure that the peroxide has a wide field of usefulness before it. As a harmless and efficient cleansing agent I know nothing to equal it.

CEPHALHEMATOMA OF THE NEW-BORN.

BY STANLEY M. WARD, M. D.,
SCRANTON, PA.

My experience with cephalhematoma has been somewhat unique, if I may judge by what the books say, and by what older physicians, and in some cases, those of large obstetric practice, have told me. Believing, therefore, with the great Chancellor, that every man is a "debtor to his profession," I submit a somewhat detailed account of that experience, at the risk of being criticized for my treatment, and perhaps, too, for my opinion.

No definition is required to explain the meaning of the word "cephalhematoma." Unlike many terms in medicine and other sciences, the term plainly expresses the condition present. Its cause is *sub judice* in a great measure. In the course of this com-

munication an attempt will be made to explain why this is so.

It would seem quite evident to the casual observer that a soft fluctuating tumor on the presenting part of the head of a new-born child was simply the result of pressure, was a "bulge," in fact, of the soft tissues, produced by the other part of the head being squeezed by the uterus. Ellis, writing in 1878, says that it "is often the result of pressure from protracted labor." Other authorities pay little attention to the entire subject, and Ellis himself devotes only ten lines to it in his work, as found in Wood's Library. Parvin, in the *Cyclopædia of the Diseases of Children*, edited by Keating, passes it by as a matter of little consequence, as does also Henoeh; so that I am constrained to believe that, by a large number of medical men, the view given above is generally accepted. On the other hand, Virchow gives an elaborate explanation which, if it be correct, stamps cephalhematoma as a diseased condition, the production of which is by no means so simple a matter as has been assumed. He says, "the pericranium grows by proliferation of the inner layers of the periosteum. If, then, the pericranium, through the blood which is poured out, is held apart from the cranium, the bone-producing layers of the periosteum being still thrown off, they cannot reach that part of the bone for which they are intended. Eager, however, to fulfil their office they join themselves to the bone at the border of the tumor where the bone is still attached." It must be evident to any one that Virchow was describing a tumor of far more consequence than a simple oedema or even a hematoma on a child's head. Besides, the tumor under consideration is not always on the presenting part, and has been known to occur in a breech presentation. Judging from the disparity of opinion among authorities as to its importance, and from my own experience, I believe there are two varieties of cephalhematoma: one variety situated between the periosteum and the cranial muscles, which is probably in all cases the result of pressure; the other is a more formidable affair, and is situated between the bone and the periosteum. This variety is, I believe, a matter of more consequence; is an evidence of a constitutional fault, and is never the result of pressure. It is, perhaps, best accounted for by Virchow's hypothesis, and, of course, may be found on almost any part of the child's head; may be double, and the presentation of the child

has nothing to do with it. It would seem as if some observers had mixed these forms and had classed the *caput succedaneum* with them, and then concluded that the entire subject was of little consequence—that all tumors on new-born children's heads, excepting cranio-tabes, hernia cerebri and meningocele were only evidences of a hard and difficult passage into this world.

The frequency with which this tumor occurs is stated by McKee, in the Reference Hand-book of the Medical Sciences "to be, so far as can be learned from the statements of authors, 1 to 235 of children born." Dr. Charles Warrington Earle, of Chicago, in a somewhat recent publication, questions the accuracy of these statements, and says cephalhematoma occurs more often. This opinion I, too, hold; for in my personal practice and as an associate with Dr. J. J. Ward, of Ellensville, N. Y., eight cases have occurred. However, practitioners of large obstetric experience, covering ten or more years, have told me that this condition was unknown to them. As before indicated, cephalhematoma is divided into varieties according to the seat of the effusion. Dr. McKee, in the article referred to, says there are four. I do not think anything is gained practically by so many divisions; and I have given only two varieties. Dr. French, of Missouri, in an article which was very helpful to me, appearing in the *Archives of Pediatrics*, March, 1884, gives as varieties the sub-aponeurotic, and the sub-pericranial. I believe a better and more correct name for the second variety would be sub-periosteal. If it be true that the first-named variety is more of a local trouble and produced by local means, then it would follow that it would be, on the whole, the more common form, and, being present at birth, would reach its maximum growth a short time afterwards; while the opposite in every respect would be true of the last named. This happens, I think, in practice.

The diagnosis from other tumors affecting new-born children's heads presents few difficulties. "A soft, elastic, fluctuating tumor, generally painless and situated on one of the cranial bones" (Earle), which, unless exceedingly large, is not particularly noticeable until from eighteen to twenty-four hours after birth and which is surrounded at its base by a ridge of bone—"nature's efforts to repair the injury" (Earle)—is not likely to be mistaken for anything else. The differences existing between the two varieties are the

appearance of the sub-aponeurotic form on the presenting part; its great size as compared with the other form; the irregularity of the ridge of bone surrounding it—not always readily found; its irregular form; with its tendency to spread and the discoloration of the skin covering it. Dr. French insists on these and other diagnostic points, and on one other which is perhaps of more practical importance than any of the others, namely, that the sub-aponeurotic—the local form, so to speak—tends to slowly diminish after a week or so, and will usually disappear without treatment in two or three weeks.

Nearly every writer consulted by me recommends the let-alone treatment of cephalhematoma. I think in some instances this is due to the failure to distinguish the different varieties and to confound the tumor with the *caput succedaneum*. This last-named tumor and the sub-aponeurotic form of cephalhematoma will in the great majority of cases disappear with or without discutient lotions, pressure, etc. But I have waited in a case of the other variety over three weeks, using this treatment, with no result. There was not the slightest evidence that the tumor was diminishing. This case had the following history: A male child was born of healthy Irish parents. The mother was a primipara, and an exceedingly large, muscular woman, accustomed all her life to hard manual work. The labor was tedious, but was finally terminated without instruments. On the second day a tumor was discovered on the right parietal bone. It was diagnosed as a tumor not connected with uterine pressure, but we were ignorant of its exact nature, it being the first one of the kind that the attending physician, Dr. J. J. Ward, or I had ever seen. The author and an elderly practitioner of a large experience, saw it during the second week and failed to diagnose it. Treatment with lotions, etc., had been faithfully carried out, with no result. It seemed as if the tumor grew every day; but this is questionable. At the end of three weeks it was as large as a fair-sized orange, regular in shape, and the bony margin was well marked. Yielding to the solicitation of parents, the attending physician, assisted by myself, opened it at the base with a lance. The blood flowed freely, the tumor diminishing in size. The wound was dressed antiseptically, absorbent cotton being used, and a bandage was placed over all. The next day the dressings were soaked with blood, the tumor was nearly as large as

before, and the child was very pale. After renewing the dressings a probe was inserted into the cut to break up possible adhesions, and the dressing was renewed. Twice daily did we dress the wound for a week thereafter, the child in the meantime becoming very weak and anemic; indeed so exsanguinated was he that doubts of his recovery were freely expressed. Finally, two weeks or more having passed, there was no more hemorrhage, and the entire tumor disappeared. The child recovered rapidly, and is now healthy and strong. I think the mistake in this case was, either in not opening the tumor sooner, or if it was deemed necessary to empty it, that we did not use an aspirator, instead of the lance, though then, because of the thickened blood, much trouble would have ensued. In seven more cases—one double—the treatment sketched above has been carried out, but with no such trouble and anxiety. The lance was used in every case at a date varying from the sixth to the twelfth day. In every case but one, the history of which follows, no untoward result followed.

That all these tumors were cephalhematomata admits of little doubt, as the first case was studied very thoroughly, it being an anomaly to all concerned. Again, though no doubt as to the nature of the tumor existed, in order to make assurance doubly sure, in no case was the operation done before the sixth day, and usually it was done later. Any other tumor, except those rare and serious forms about which a mistake is not likely to be made, would have disappeared before that time. Several of the cases were the more common and the less serious cephalhematoma sub-aponeurotica, appeared on the presenting part and had the ridge of bone imperfect. In some cases the covering of the tumor was discolored; in some, even of the sub-aponeurotic form, it was not. In all the same treatment was carried out, as we deemed it innocuous, and as it is very gratifying in its results to the anxious mother who wishes her child to be in a presentable condition at least by the end of the second week. My last case is as follows:

November 26, 1889, I was called to see a German woman, who had been attended in her confinement some days before by a midwife. I found her in a condition of sepsis, produced evidently by the uncleanness of the lacerated external genitals. On the occasion of my fourth or fifth visit, my attention was drawn to the child by the

midwife. On examination, I found a male child, to all appearance healthy and well developed; but, occupying the lower part of the right parietal bone, was a tumor. The midwife said she had not noticed it at the child's birth. All the characteristics of a sub-periosteal cephalhematoma were present, and I so diagnosticated it. The next day, the child being twelve (12) days old, I lanced the tumor at its base. A quantity of blood, not enough to hurt the child—which indeed hardly waked from its sleep—came slowly from the cut, and the tumor diminished by degrees. On the next day the child was not feeling well. It was cross and irritable. Some blood had oozed out during the night; but the tumor was about one-quarter its original size. With a probe I opened the wound and carefully pressed out the blood, and dressed the wound with absorbent cotton and applied pressure. On the following day the tumor was gone, but the child was in a bad condition, was listless and inclined to sleep. When roused he moaned and cried a little. Ecchymotic spots now appeared over one side of his face, and part of the chest and the scrotum were greatly enlarged and reddened. In fact, many symptoms of purpura hemorrhagica were present. Two days afterwards he died of exhaustion and inanition. I am not certain that my interference had anything to do with the death; but, if I had never operated before, such an opinion would have appeared very probable to me. It will be noticed that the disaster was not such as the advocates of the "let alone" treatment state will follow interference, at least so far as I know.

These two cases are the only ones of the eight that presented any features worth commenting on. Reasoning from experience and from what we know of the pathology of these tumors I believe, in spite of what many authorities say, that to make a free incision at their base; to gently press them; and finally to dress them with boiled water, applied freely; and to cover them with a roller bandage, is good treatment. Even if convinced that a given tumor is an example of the simplest form—the sub-aponeurotic—if after pressure moderately applied, it should show no signs of disappearance at the end of a week or ten days, I believe the good of the child, certainly the comfort of the mother, would be best secured by the operation described. I think in some cases aspiration would be safer; but before sug-

gested, on account of the thickened condition of the blood, especially after the second week, much difficulty would be experienced.

CONSUMPTION RETARDED, IF NOT CURED, BY AN ACCIDENT.

BY JOHN B. CRANDALL, M. D.,
STERLING, ILL.

Mrs. Henry Thomas, 62 years old, a resident of Sterling, was in the second stage of tubercular consumption; had great emaciation, with severe cough, night-sweats, hectic chills, and all the other rational symptoms. This state of affairs was progressing when she met with an accident. She slipped on the sidewalk and fell down, fracturing the right femur. Upon examination, I found introcapsular fracture of the right femur. Mrs. T. was in such a deplorable condition generally I did not put the limb in splints but had an adjustable leather support to steady the limb, so that she could sit up in bed, in order to ease the severe strain and cough. She progressed as well as any case could, so far as the treatment for fracture was concerned. As soon as the deposit of callus on the fractured bone commenced there was marked improvement in her cough, she ceased to have hectic chills, the expectoration became less, and was less tenacious in character, and her general health improved. She gained in weight, and all the symptoms of lung disease were checked.

This coincidence happened more than ten years ago; and the woman has been up and about since, with no recurrence of lung trouble.

In this case, as soon as the deposit of bone began to be thrown out there was a marked improvement in all of the pulmonary symptoms. Whether or not this fact indicates a line of treatment for tubercular phthisis I leave for the philosophers in the profession to determine.

SANTONIN.—The competition among the Russian santonin-makers has continued throughout the past year, and this has led the Chim Kent works again to reduce their price for the article by 25 per cent. The present quotation excludes the possibility of manufacturing santonin profitably in Germany.

REPORTS OF CLINICS.

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SERVICE OF DR. ROBERT COLTMAN, JR.

Leucoma.

This little girl is twelve years old. At three she was attacked by small-pox in the confluent form, and she is badly pox-marked; but the disease did more than destroy her good looks: it has robbed her of her eyesight. The right eye has suffered most, and is hopeless from straphyloma and a leucomatous cornea. The left eye is almost hopeless, also due to leucoma; but, as there is a clear space of cornea just at its outer margin, I propose to perform an iridectomy, in hope of obtaining at least partial sight. I nearly always use a Beer's knife for the incision of the cornea, and shall do so here. I draw the iris out through this incision, and clip off a good-sized piece close to the cornea. In this case a very large false pupil will do no harm, as it cannot be seen, and a small one might not be sufficient. You observe that the iris remains caught in the lips of the wound. It is important to replace it before it becomes attached in its present position, which it would be sure to do. For this purpose I use the iris forceps, simply pushing the incised surface back into the anterior chamber. The instillation of two drops of an atropia solution (one grain to a fluidounce of water) completes our present treatment of her case. Her eyes we will keep closed for two days, when we shall see her again. I fear the result will be poor, as the cornea has such a very slight area unclouded; but in her desperate condition even a little sight will be a boon.

Psoriasis Capitis.

This boy is fifteen years old. His head looks as if he had a white night-cap on, and his hair has nearly disappeared. This is an unusually bad case of psoriasis capitis. In some places you see large white scales collected into little heaps or hills; these are called "rupioides." When I first came to China I experimented with a number of remedies for the cure of this complaint, with very little success; but now the cases uniformly recover in a very short time. My treatment is: wash thoroughly in warm water each morning; then wipe entirely

dry, and anoint with an ointment composed of equal parts of *pix liquida*, oleate of mercury (five per cent.) and *cosmoline*. Internally I give ten-drop doses of *syr. ferri iodidi* after each meal. We will put this lad upon this treatment, and direct him to return in five days, when I promise you he will present a different appearance. As for the loss of hair, I fear it is permanent. In some of the milder cases the hair follicle does not die, but lies quiescent; and, when the disease is removed, again sprouts a hair; but in a case as severe as the present one the disease is deep-seated and has probably destroyed the hair follicle.

Pterygium.

This man, a farmer, fifty-three years old, comes to us for an operation the second time. You will remember that I operated on him for pterygium a month ago, and, after dissecting back the growth, made a small incision in the conjunctiva at the margin of the lower lid, and, diverting the end of the growth into this incision, fixed it there by one point of suture. This is called transplanting, and is by long odds the best way of treating these cases. But this man, in spite of my injunctions, kept wiping his eyes with a coarse cotton handkerchief, and soon tore out the point of suture, allowing the growth to become free and unattached. This has grown in thickness, and worries him, as it flaps back and forth as he rotates his eyes. I shall simply dissect it back to the inner canthus, excise it, and then touch the stump and bleeding surface with a piece of copper sulphate. This will give him relief for some time, but in a period of from six months to three years the entire growth will probably be reproduced, and will necessitate the transplanting operation again.

Chronic Diarrhoea.

This man, fifty-three years old, is an officer in the Civil Service. He says that three years ago he caught cold near the sea-coast, and that a diarrhoea followed, and has kept up until the present day. At first he had four stools a day; then more; and now he has ten in twenty-four hours, and also some blood in them. The fact that he has very little pain is probably accounted for by the fact that he takes two drachms of opium daily. He is anemic, and somewhat jaundiced. His liver is somewhat enlarged; his heart, lungs and spleen are normal. I find

—no matter what is the trouble with an opium-eater—that quinine, or some salt of cinchona, is an important adjunct to the treatment; so I shall prescribe for this man the following:

R *Cupri sulphatis* gr. ss
Quiniae sulphatis gr. xii
Ext. taraxaci gr. xii
 M. Ft. pill No. vi.

Sig: One pill three times daily.

He will report at the end of two days. This patient will probably be hard to cure. He will do well for a time, but will relapse because of indiscretions in diet. I shall order him to abstain from everything in the way of food, excepting soft boiled rice and warm milk. He will certainly improve steadily for a time; and he will as certainly add other articles to his diet before he has permission, and delay, if not prevent, his recovery.

Scabies.

This is a sorry-looking group: father, mother, boy, girl and baby. It is not often that all the members of a family have the same complaint, but when it does occur it is probably—as in this instance—the itch. You will notice that the mother, who is the cleanest looking of the lot, has the affection in the lightest degree; while the boy, who is extremely dirty, is a mass of sores.

Itch is always more common at the end of winter, because people crowd together more during cold weather, and wash less. We will suggest to this group of patients that they take a bath, and then anoint themselves with an ointment of two drachms of sublimed sulphur to an ounce of *cosmoline*. Several repetitions of this process will ensure a cure.

SUGAR OF MILK.—The fine recrystallized varieties of sugar of milk produced in Northern Germany have been very scarce, while the supply from Switzerland has been forthcoming on a somewhat more liberal scale. The strong demand from the United States for both varieties continues, notwithstanding that there are now facilities existing in the States for the wholesale production of sugar of milk. It is said, however, that neither the grape form nor the crystallized variety of sugar of milk is made in the States, but only a rather unsatisfactory powdered product, which would scarcely be suitable for homœopathic purposes, although it has a very large sale in America.

FOREIGN CORRESPONDENCE.

LETTER FROM PARIS.

Erysipelatous Broncho-Pneumonia without Erysipelas of the Cutaneous Surface.—Treatment of Fractures of the Patella by the Extensive Opening of the Knee-Joint. Excision of the Transverse Process of the Seventh Cervical Vertebra, for Compression of the Bronchial Plexus.—Treatment of Hydrarthrosis of the Knee.—Surgical Treatment of Club-foot.—The Mixed Diet for Infants at the Paris Maternity.—Treatment of Anthrax.

Dr. Mosny recently presented to the Academy of Medicine of Paris some interesting observations on erysipematous broncho-pneumonia. This location of erysipelas has been denied for a very long time. In 1879, Dr. Strauss recorded a case of this description, and during the recent epidemic Dr. Mosny came across the following case:

A servant girl who was nursing her master, suffering with facial erysipelas, was taken with pneumonia and died two days later. At the *post-mortem* examination, there was found a very limited area presenting the characteristic appearances of broncho-pneumonia. Bacteriological tests and cultures showed the development of characteristic colonies of the streptococcus of erysipelas, without the admixture of any other micro-organisms; and inoculations have, moreover, demonstrated that this streptococcus was identical, as to its effects, to the streptococcus of erysipelas. The conclusion is that this case was a primary erysipematous broncho-pneumonia, having not been preceded by any cutaneous or mucous manifestations of erysipelas, nor by any streptococci supuration.

Dr. Lucas Championnière also presented to the Academy the results of fourteen cases of fractures of the patella which he has treated with the metallic sutures. When the operations were performed immediately after the injury, that is, within the twenty-four hours, the results were much more favorable. The operator opens the knee-joint very broadly, washes it out very carefully, and under the most antiseptic rules, he removes any splinters of bone which may be present, and finally sutures the bone, the patella, by means of very

strong silver sutures; two of these, being passed through its substance, are sufficient. Drainage-tubes are inserted so as to enable the neighboring parts of the articulation, which are the seat of effusions, to empty themselves. The limb is then placed, for a period of eight days, in a wire splint, and a simple dressing applied. Never is the articulation rendered absolutely immovable, Dr. Championnière insists on this point. At the end of from twenty to twenty-five days the patient is allowed to begin to walk, when osseous union is already established, as one is unable to find the line of fracture of the bone.

When the operation is performed by any of the several other methods usually employed, the result is not so good; out of five cases, in two cases only did he obtain perfect union between the fragments; in the other, he was unable to bring the fragments close to each other and so he left the silver sutures in position and they gave no trouble.

Dr. Périer presented an interesting case of the excision of the transverse process of the seventh cervical vertebra. The patient, a young man, had been suffering for many years with severe pains in his right arm, accompanied by a very marked atrophy of the same extremity; while at the same time his voice was very much interfered with, which seemed to indicate serious lesions in the laryngeal region.

Upon physical examination a very apparent projection on the right side, above the clavicle, was found, also one on the left side, but less prominent; and the whole neck was enlarged. These projections were the transverse processes of the seventh cervical vertebra, the right one being very much developed; and on a level with it, one could feel the beating of the subclavian artery. The brachial plexus, which was displaced, is also compressed, which accounts for the severe pains, the muscular atrophy, the alteration of the voice due to the compression of the recurrent nerve. The operation was a difficult one, the transverse process was excised, and during this operation the plural cavity was opened, but this accident, after having determined, on the following day, a severe dyspnoea and a sub-cutaneous emphysema developed on account of the introduction of air into this serous cavity, but this disappeared in a few days. The patient was then subjected to electricity, gymnastics, douches, etc., and since then his arm has completely recovered its use, the pains have

disappeared, and the voice has become normal again.

At the Société de Chirurgie, Dr. Terrillon spoke on the treatment of hyarthrosis of the knee (effusion in the joint), by means of aspiration, and subsequent injections of carbolic acid solution. He presented a young woman, whose knee he had aspirated, and had obtained six hundred grammes of liquid from the joint. The case was one of hyarthrosis of six years' duration, which had rendered the patient absolutely incapable of walking. Five syringefuls of strong carbolic acid solution were injected, altogether 1,300 grammes, to wash out the cavity; and compression was then applied. The patient was discharged as cured at the end of a month. One year after the operation, there was still a little liquid in the joint, but the patient now walks perfectly well.

At the same society, Dr. Lucas Championnière spoke on the treatment of club-foot by extensive excision of the tarsal bones. The principal part of the operation consists in the bony destruction, and especially the extirpation of the astragalus, followed by section of the tendon Achilles. The excision of bones must be sufficient to bring on a complete correction of the deformity. There is no objection in taking away as much bone as necessary, and in one case the author had excised the astragalus, the scaphoid, part of the cuneiform and the cuboid and calcaneum. As to the cutting of the ligaments, they are not of great importance; and the only bone that must not be removed is the external malleolus.

After extensive excisions, the foot is so firm that a containing apparatus is hardly necessary; hence a large removal of both soft and bony parts is to be recommended; moreover, an extensive bony excision greatly helps the union of the soft parts after the operation, and this immediate union is very important for the success of the operation, for we must not rely upon consecutive treatment to complete the reduction; this must be immediately obtained and by operation. The wound heals after one or two antiseptic dressings; the movements of the foot must be commenced early; the patient should be able to walk well at the end of six weeks. At first, Dr. Championnière recommends a boot with lateral splints, to prevent lateral movements and sprains, but later the boot is hardly necessary. Out of eight cases, he has had six perfect successes; the seventh was very slow in walking; and the eighth

resulted poorly, which he attributes entirely to not having excised enough bony tissue.

Dr. Berger, out of six cases, has had four attended with perfect results. The two resulting imperfectly were cases where the bony resection had been very limited; while in the four successful ones, the bony excision had been a very extensive one. Dr. Berger insists upon not using drainage and only applies one dressing between the fifteenth and twenty-first day. A plaster-of-Paris splint is placed immediately over large cotton dressings. His patients begin to walk in four and five weeks; later they wear boots but without lateral splints.

At the Paris Maternity, Madame Henry, the midwife-in-chief, gives a mixed diet to infants in the following manner.

The mixed diet is the one to be recommended when a mother is unable to furnish enough milk to her child on account of insufficient secretion; or again, when the financial position of the mother prevents her from keeping a nurse in the house; this mixed diet consists in feeding by the breast in addition to other food. At the Maternity, the hours of feeding are as follows:

8 A. M.—Breast feeding.

11 A. M.—Breast feeding.

1 P. M.—Milk or equal parts of milk and distilled water.

3 P. M.—Breast feeding.

5 P. M.—Milk or equal parts of milk and distilled water.

8 P. M.—Breast feeding.

11 P. M.—Breast feeding.

1 A. M.—Milk or equal parts of milk and distilled water.

3 A. M.—Breast feeding.

5 A. M.—Milk or equal parts of milk and distilled water.

The mixture of equal parts milk and distilled water may be replaced by gruel containing 3 per cent. of sugar of milk.

The milk must always be boiled.

If diarrhoea appears, Madame Henry prescribes the following mixture:

Rum 3 teaspoonfuls.

Water 1 tumblerful.

M. Sig.: Give three or four teaspoonfuls in the twenty-four hours.

If this is not sufficient, the following prescription is used:

R Napthol B gr. j
Water f 3j

M. Sig.: Two or three teaspoonfuls in 24 hours.

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Dr. Polaillon, of Paris, treats anthrax, which he considers an essentially microbic disease, by destroying the centre of the lesion; he prefers to the use of the knife, Paquelin's thermo-cautery, or better still, Canquoin's paste (chloride of zinc, $\frac{3}{4}$ ss, wheat flour, $\frac{3}{4}$ ss, water, q. s.) made into a cone and introduced into the tumor, through the suppurating channels. In a few hours the core of the anthrax forms a solid mass, which is separated from the healthy tissues by cauterized tissue, and in a few days the eschar is eliminated, leaving a granulating surface, which heals very rapidly. When the anthrax begins, and there is no existing suppuration, he uses compression and poultices on which a carbolic acid solution or bichloride solution has been placed, using antiseptic water to make the poultice. This treatment is painful to the patient for one, two or three hours, but it rapidly breaks down fever and all other alarming symptoms. Out of 75 cases of anthrax, some of them very large, Dr. Polaillon has obtained 74 cures by cauterization by means of the cones of chloride of zinc. The average duration of the treatment is about twenty-one days.

LETTER FROM LONDON.

Specialists and Abuse of Hospitals.—Signor Zucci.—Prevention of Ophthalmia in Schools.—Dr. Savage on General Paralysis of the Insane.

LONDON, April 5, 1890.

The Easter holidays have fallen in the midst of mild and lovely weather, and the Registrar-General's returns have already shown a sharp fall in respiratory diseases. Still, in a climate like that of Britain, where snows are not unknown in May, one can never be quite sure that the warm weather has come for good. All the world is now flocking to London. The next few months will bring in the harvest of the specialists, who have a comparatively quiet time of it during the winter: at any rate so far as their consulting rooms are concerned. There is never any lack of patients in the special departments of the hospitals; indeed, the complaint is all the other way, that outpatient departments generally are unwieldy and filled by an ever-increasing crowd of applicants for relief.

This question of hospital abuses has at length forced itself upon public attention,

and the agitation for reform is assuming more definite lines of action. In the House of Lords it was officially stated that Government would not be averse to the appointment of a Royal Commission of Enquiry into the administration of public charities. The provinces have taken up the subject vigorously. In Birmingham, for instance, the Mayor has formed a committee of investigation having a judge for its chairman; and much discussion has been carried on in the newspapers of that town. In Liverpool the reformers have been especially active, and have issued numberless schemes and resolutions. Then the Charity Organization Society—here, as in America—well-nigh buried beneath the caustic comment that so much of its time was spent on organizing as to leave none for charity, seems to have taken a fresh lease of life, and has convened a large meeting to consider the audit and preparation of accounts of charitable institutions. All these signs of the times show that the question has thoroughly awakened public interest. General practitioners, who have long clamored for reform, will now have to prove their case, and the fear is openly expressed in certain quarters that exact evidence will not be forthcoming. It is one thing to say that well-to-do people get their advice and medicine gratis, but quite another to bring forward clear and formal proof of that assertion. Anyway, it may be confidently hoped that the matter will not be allowed to drop out of sight before being pushed to a satisfactory conclusion. Many people look to an extension of Poor-Law medical relief for a solution of the difficulty, and such a course would be quite in accordance with the modern tendency to apply the rules of political economy to social problems.

Among the holiday sights is Signor Zucci, the fasting man, on view at the Aquarium. He is pledged to fast for sixty days, taking nothing during that time beyond water and an "elixir" of his own composition, which contains no nutriment, but is intended simply to allay the pangs of hunger. His proceedings are carefully watched night and day by a body of journalists and medical men. Among the latter are several residents from the Westminster Hospital, which, as every one knows, is close to the Aquarium. The gentlemen who have thus allowed scientific zeal to outrun their discretion have got well "hailed over the coals" both by the hospital management and by the

medical journals, apparently on the following grounds: Although it is possible that fresh light may be thrown on the chemistry of starvation, and that some value may attach to the fixing of more exact dates of survival, yet hospital officials, on the score of such doubtful benefits, cannot be allowed to play, however unwittingly, into the hands of advertising speculators. Besides, the fasting game has long had its *coup de grâce*. One journal pithily remarks that there are plenty of starving men to be seen any day without paying a shilling a head for the sight.

The personality of the late Sir William Gull has been sworn under £350,000. There is, in addition, a large real estate, bringing up the total sum to very big figures. As may readily be imagined, the bulk of this vast fortune was acquired outside the practice of the profession. The singular absence of charitable bequests has been made the subject of comment in some of the medical papers.

An interesting advance has been made in the treatment of ophthalmia in pauper schools. The Central London District has an extensive educational institution in the outlying suburb of Hanwell. Ever since the foundation of the school—now more than twenty years ago—there has been repeated outbreaks of the disease, which have never been altogether absent from the place. During that prolonged period reports have been made by experts from time to time, strongly condemnatory of the buildings and also of the methods of treatment. Towards the end of last year the matter was taken up warmly by the press, both lay and medical, and it was also made the subject of Parliamentary comment. The history of these proceedings—the twenty years' delay, the slow ripening of opinion, the leverage of the newspapers, and the question in the House, together present a typical picture of how things of that sort are done in England. Slow and steady are the ways of John Bull. However, the Hanwell managers at length took the decisive step of appointing Mr. Sydney Stephenson, an eye-surgeon who had before stamped out an epidemic of a similar nature at West Norwood, to the sole charge of ophthalmic cases. The next requirement was the erection of new buildings. This has now been done at a cost of £30,000—a mere trifle when one reflects that the ratable value of the City of London, which along with the parish of St. Saviour's, Southwark, makes up the Central District,

is no less than four millions sterling. Details of construction have been arranged in accordance with modern knowledge. Although scientific men have not proved the exact causation of ophthalmia, yet it is an accepted axiom that isolation, prolonged and thorough, is a *sine quâ non* of its successful treatment. In isolation, therefore, lies the key to the new buildings. Washing is on the "jet" system, by which each patient washes in a separate stream of running water. The baths are of spray, turned on by the child's weight; a plan that reduces the risks of infection and saves water. The most novel feature, however, lies in the fact that isolation, medical treatment, and schooling will be carried on at one and the same time. This is the first departure of the kind in England, although the plan has been tried elsewhere. There can be little doubt that enlightened measures of this kind will eventually banish all existing cases and future epidemics of this pestilent scourge from pauper schools.

Dr. Savage has lately read a valuable paper before the Harveian Society on the warnings of general paralysis of the insane. He regards the malady as a degeneration rather than a specific disease. Speaking broadly, the slave has acquired, with freedom, general paralysis; which, to put it in other words, is a disease of civilization, in direct ratio to the high-pressure life of cities. It is often very difficult to distinguish between causes and early symptoms; for while drink, extravagance, restlessness, and sexual excess may, one or all, start the degeneration, they may, on the other hand, simply show loss of self-control. The bearing of early motor changes, such as fatigue and resulting indecision is pointed out; and of ataxic changes with muscular defects of the hands and tongue, blurring of the features, aphasia and altered handwriting. Sensory warnings include neuralgia, sciatica, headaches and rheumatic pains; with defects of special senses. Among intellectual changes are: want of social accommodation and such faults as stupid stealing and thoughtless indecency. And the curious point is that patients get drunk easily, and cannot resist poisons.

D. W.

—Tinned cherries have given rise to symptoms of poisoning, which Dr. A. P. Luff and Mr. G. H. Metcalfe have traced to the presence of malate of tin.

PERISCOPE.

Prejudices about Foods.

In his address before the Chemical Society of Washington last January, Mr. Edgar Richards called attention to the objections some people have to food liked by others.

A large proportion of the articles suitable for food and produced in all countries, he said, is wasted annually because of people's prejudice against them. The old saws, "What is one man's meat is another man's poison," and "There is no accounting for taste," are trite, but warranted by the facts. We do not object to eating a live oyster, but prefer all our other meats dead, and undergoing putrefaction to a slight extent, in order to get rid of the "toughness," as it is generally called, produced by the *rigor mortis*. Some people like to let the putrefaction proceed further until the meat is "gamey." The Texan cowboy eats goat's meat in preference to that of the cattle and sheep he is herding. Young puppies, rats, and bird's nests are considered delicacies by the Chinese. Frog's legs and snails are among the highest priced dishes served at Delmonico's. Except the bones and hide, every part of an animal slaughtered for food is eaten by most civilized nations—the brain; tongue; blood in the shape of black pudding and sausages; the liver; heart; lungs; stomach as tripe; the pancreas, thyroid and sublingual glands, which are called sweetbreads, and considered a great delicacy; the feet in the way of jellies, and pickled; the intestines as sausage covering, etc. In the markets of Paris there is a steady demand for horse-flesh as food. The Arabs and other nomadic tribes prefer mare's or camel's to cow's milk. Many people would as soon eat a snake as an eel, yet the latter commands a higher price than most fish in many parts of the world. Lobsters, which are the scavengers of the sea, are eaten by people who would not touch pork. The Eskimo, who eats blubber and other solid fat, and the native of the tropics, who "butters" his bread with a liquid vegetable oil, have the same object in view: viz., to supply a concentrated form of fuel. The squirrel is considered a great delicacy in many parts of this country, but is not eaten in England. The vain efforts of Professor Riley some years ago to induce the starving people of Kansas to eat the food they had at their doors—grasshoppers, sorghum, and millet seeds,

and squirrels—himself setting them the example, will be recalled by many present.—*Science*, Feb. 7, 1890.

Damage by Disinfection with Sulphur.

Dr. H. R. Carter, of the U. S. Marine Hospital Service, writes to the *Journal of the American Medical Association*, April 5, 1890, that it is well to know that sulphur burnt in the presence of moisture may have the following undesirable effects: It injures the colors of many woolen goods, being especially hard on greens and bright reds—a red flannel shirt, for instance, always comes out yellow, sometimes the color is not affected; the dark blues are generally absolutely uninjured, but not rarely turned a reddish brown. The same color, of course, may be from very different dyes and thus give different results. The quality of the dye, as judged by the price of the fabric, is no criterion of how it will behave under sulphur. Clothes that have been worn are frequently discolored, when new ones, of the same nature, from the slop chest are but little or not at all affected, doubtless protected by the oil used in weaving, which has not worn off. Dr. Carter has seen but few colored goods, other than woolen, submitted to sulphurous acid gas; in some instances they were bleached.

Articles containing starch, if not washed soon, are corroded—this is especially true of handkerchiefs, etc., and the cloth covers of books. Blankets and hair pillows, which are utterly unsuited to the process—will retain for about a week a smell so disagreeable, in no sense like that of burning sulphur, that they are unpleasant to use. This persists in spite of airing and exposure to the sun, but is immediately removed by washing, or heating in an oven.

Flour in ordinary barrels will not "rise" with yeast for some days after exposure, and this effect penetrates for a considerable distance in the barrel. Tea is ruined permanently, as is ground coffee. The same charge is made of its effect on smoking tobacco.

All metal-work, all save gold, is tarnished, with consequent injury to watches, clocks, etc. Oil prevents this almost entirely. Apples and other fruit become scalded and worthless.

The gas in Dr. Carter's observations was obtained by burning as much sulphur as

possible in the presence of abundant moisture in a compartment more or less close, kept closed for from twenty-four to forty-eight and occasionally seventy-two hours. In general it was not possible to enter the compartment for some time—thirty minutes to an hour—after opening up. Where the apartment is more open less injury would be done and also less efficient disinfection.

Detection of Tubercle Bacilli.

The *Deutsche Medizinische Zeitung*, March 27, 1889, cites the following method for the detection of tubercle bacilli, as devised by Bliesener and described in the *Centralblatt für Bakteriologie*. The sputum is allowed to dry on a microscope cover-glass, and is then passed three times through an alcohol flame. The glass is then laid, with the specimen side up, upon a small tin plate about an inch and one-half square which is fastened to a support about six or seven inches high. With a pipette five or six drops of Ziehl's carbal fuchsin are placed upon the glass, and then the tin is warmed over the flame until first bubbles appear. The flame is now removed, and after a minute the glass is washed with water, and the cover-glass is allowed to float for fifty seconds upon a staining fluid made of

Methylene blue	1.5 parts
Distilled water	100.0 "
Sulphuric acid	25.0 "

After this the specimen is washed with water and is ready to be examined under the microscope.

The Vesicoscope a Source of Error.

A remarkable instance of the way in which even the most skilled are liable to be mistaken in drawing conclusions from physical signs was given in a paper read last week by Mr. Mayo Robson, of Leeds, at the British Gynecological Society. The urine of a woman who had long been ill was found to be constantly loaded with pus, which, by means of the vesicoscope, was ascertained to come from the left ureter. On the strength of this apparently conclusive indication pyonephrosis was diagnosed, and the kidney was accordingly cut down upon. To the surprise of everybody concerned, this organ was recognized to be perfectly healthy, and a subsequent operation proved that the

source of the purulent discharge was a pelvic abscess, which had established a fistulous communication with the left ureter. It is satisfactory to have to report that relief was ultimately afforded, and cicatrization of the abscess cavity obtained.—*Medical Press and Circular*, March 19, 1890.

Hypnal.

Hypnal is a new hypnotic remedy as its name indicates. It is a trichloracetyl, and its full name is dimethylphenylpyrazolon. The drug is obtained by the action of chloral upon antipyrin. It possesses the hypnotic and sedative properties of both its constituents. At the meeting of the Société de Thérapeutique de Paris, held March 12, and reported in the *Progrès Médical*, March 22, 1890, Dr. Bardet read an account of his experiences with the drug. He gave hypnal in fifteen-grain doses. In twenty-two cases of insomnia sleep was easily induced. Excellent results were obtained with the preparation in the treatment of insomnia incident to pain or cough. Hypnal is free from the taste and caustic quality of chloral, and does not irritate the stomach. It is easily administered, especially to children.

Treatment of Diphtheria.

Dr. Waxham, of Chicago, writing on diphtheria, says that there is no specific for diphtheria, and insists upon clinging to old and well-established methods of treatment. The frequent use of iron in full doses, free stimulation, abundance of nourishment, watchful care, antiseptic gargles and washes for the throat and nose, strychnia and digitalis in case of depression, and the bichloride of mercury when the larynx becomes invaded—these remedies, he believes, are our sheet-anchors in the treatment of diphtheria, and no specific remedy can displace them; while isolation, ventilation and disinfection are safeguards that should never be omitted.

OXYURIS VERMICULARIS.—The oxyuris vermicularis is said to promptly disappear with injections per rectum of cod-liver oil, pure or made into an emulsion with the yolk of an egg. It is non-irritating, and is said never to have failed to effect a cure.

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The Editor will be glad to get medical news, but it is important that brevity and actual interest shall characterize communications intended for publication.

THE PENNSYLVANIA STATE MEDICAL SOCIETY.

It has been unfortunate for the Medical Society of the State of Pennsylvania that two years should elapse between two successive meetings; but this became necessary on account of the unparalleled disaster associated with the name of Johnstown, which visited not only that town but at the same time a wide extent of the State, at the very date appointed for the meeting of the State Medical Society.

The long interval that has elapsed since the Society met in Philadelphia will probably make it harder to get a first-rate meeting this year than it would have been if only the usual interval had come between. It is probable that some men may have lost something of the zeal which they felt a year ago in regard to subjects they were then investi-

gating, and that some of the discussions which were carried over from the Philadelphia meeting will suffer from this long interruption. Nevertheless, we trust that our professional brethren throughout the State will come up to the meeting determined to make it one of the best we have ever had.

It is now time for them to be notifying the Committee of Arrangements of the papers which they mean to read, and the topics they would like to have discussed; and we would urge them to be prompt in doing so.

There are several subjects which are pretty sure to come up for consideration; and the readers of the REPORTER might be preparing for them. Among these we think it safe to name the matter of the law for a State Board of Medical Examiners; the relation of superintendents of State Hospitals for the Insane to the management, and the nature and recent history of hydrophobia.

These and other topics of great practical importance ought to have full and free discussion; and it is to be hoped that some of them, at least, will be advanced to, or near to, definite conclusions. In regard to all of them very diverse opinions are held by different members of the Society, and these opinions ought to be thoroughly discussed, with an earnest determination to arrive at conclusions which shall be true to the demands of the profession and useful to our fellow-men.

In addition to such discussions of public questions, we hope there will be a good number of well considered papers on subjects of theoretical and practical medicine, and that the whole meeting may add to the reputation of the Society and of the physicians of Pennsylvania.

DIAGNOSIS OF FOLLICULAR TONSILLITIS.

At this season of the year, when both diphtheria and follicular tonsillitis are especially common, a physician is often called upon to make a diagnosis between

the two affections. Such a differential diagnosis is confessedly one of great difficulty. It is true that in some cases the physician is not compelled to express an opinion, and then he may keep his doubts to himself and await further developments before coming to a positive conclusion. In the majority of instances, however, he is asked, "What is the matter with the child, Doctor; is it diphtheria?" almost before his examination of the patient is completed. When the one who is thus cornered and compelled to state his opinion is the family oracle, whose patients hang upon his words, an expression of doubt as to the real nature of the case and a desire to delay before giving a decision, will be accepted as equivalent to saying that no one can make a diagnosis, so great is the obscurity. When, however, the practitioner is one less highly esteemed, a suggestion of doubt on his part as to the nature of the throat affection is likely to be met on the part of the family by doubt of the medical man's skill. But, whether he suffer in reputation or not, for his own peace of mind and from his love of scientific accuracy, he will desire to be sure of his diagnosis in every case. Practically, this may be unattainable; nevertheless, if sought for, a nearer approach to it will be made than though the practitioner were content to remain in doubt.

To begin with, it may be said, with a fair degree of accuracy, that follicular tonsillitis is more acute in its onset than diphtheria. In the latter affection, more than in the former, there is likely to be a history of preceding indisposition. The child appears to be ailing, with lassitude, perhaps peevishness, takes less interest in its playthings and has an impaired appetite. At the beginning, a chill, or various creepy, chilly sensations, are more common in follicular tonsillitis than in diphtheria. In the early stages, also, the throat symptoms are more marked in the former than in the latter. The child has some pain in deglutition; at times the degree of pain is far in excess of any mani-

fest local disease. This is especially apt to be the case when influenza is prevalent; in such cases the throat is pale pink and cedematous. The tonsils at this time are seen to be somewhat enlarged, but they do not project beyond the arches of the palate. In a few hours one may be surprised to find that the temperature has risen to 102° or 103° Fahr., the tonsils swollen so as nearly to close the throat, and covered by a layer of thick, cheesy, yellowish-white exudation from the crypts of the tonsils. When they are seen in this condition the diagnosis from diphtheria can be made by remembering the well-known fact that the exudation described is on the tonsil, but not adherent to it; it can, therefore, be brushed off with a camel's-hair throat brush, or wiped off with cotton on an applicator. In diphtheria, on the contrary, the covering of the tonsil is a membrane, is adherent to it, so that in endeavoring to remove it the membrane comes off in pieces or strips and leaves a raw, bleeding surface beneath. Moreover, the color of the diphtheritic membrane is generally grayish, whereas, as stated, the exudation in follicular tonsillitis is generally of a yellowish-white tinge. In a few cases of a milder type, in which the constitutional symptoms also are less pronounced, instead of the characteristic deposit already spoken of there is a thinner, grayish-white layer, closely adherent to the tonsil. It is next to impossible to tell this kind of case from one of diphtheria by the throat symptoms alone. It will be in favor of tonsillitis if the disease developed rapidly following a chill, if the child has had rheumatism or growing pains, or if the other members of the family are inclined to be rheumatic or gouty.

The general aspect of the patient at times helps us to decide the question. The same amount of membrane on the tonsil will, if diphtheritic, produce more evidence of constitutional involvement than is the case in follicular tonsillitis, notwithstanding the fact that the greater discomfort so far as the throat is concerned is experienced in the

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latter affection, there is an indefinable something in the eye and complexion of patients which tells us that they are or are not seriously ill.

The result of treatment is also of value in diagnosis. The use of guaiac locally and internally frequently brings about a very rapid improvement in tonsillitis, but its use has no noticeable effect upon diphtheria.

Albuminuria is more common in diphtheria than in follicular tonsillitis, and this fact may be of service in deciding the question in a doubtful case.

The points of difference between these two affections are not many, and no one of them is sufficient in itself to enable us to make a diagnosis; the entire group of them, however, taken together and applied with calmness and clearness to the diagnosis of a doubtful case, will enable the practitioner to arrive at a satisfactory result in almost, if not quite, every case.

CAMPHORIC ACID.

The medicinal properties of camphoric acid have received but little attention at the hands of even the most recent writers on therapeutics. Biddle and Tidy merely mention it as a derivate of camphor by oxidation. Brunton, Edes, Farquharson and Wood, in their respective works on therapeutics, make no mention of it whatever. Merck's index speaks of its recent introduction into therapeutics, and mentions its use both by inhalation in diseases of the air-passages, and also as a surgical antiseptic.

The acid may be procured by prolonged boiling of nitric acid with camphor; the products of this oxidation being camphoric acid ($C_{10}H_{16}O_4$), and camphoranic acid ($C_9H_{14}O_6$). Attfield, however, gives the formula of camphoric acid as $C_8H_{14}(COOH)_2$.

Fürbringer was the first who called attention to the therapeutic properties of the acid. He classed it among the aromatic acids, and speaks of it as having antiseptic properties. Fürbringer used the acid in

typhoid fever and enteritis, but although large doses were exhibited the drug failed to influence the process of the disease in any way.

In cystitis, especially in cases complicated by an ammoniacal decomposition of the urine, the acid checked the fermentation, but had no beneficial influence upon the suppurative process. An unlooked-for action of the drug was observed in tuberculous patients. Fifteen-grain doses exhibited three or four times a day, in most cases caused a complete cessation of the night-sweats. While Fürbringer was conducting his experiments in Vienna, Reichert, in Berlin, was similarly studying the action of this drug, with the view of ascertaining its value in acute and chronic diseases of the mucous membrane of the respiratory tract; also in certain cutaneous affections. Owing to the acid being but slightly soluble in water, a solution in alcohol and water was employed. In catarrh of the mucous membrane of the throat a one-half to two per cent. solution was used as a gargle with favorable results; the duration as well as the intensity of the disease being considerably lessened under its use. In cases of chronic catarrh a six per cent. solution was employed with highly satisfactory results.

Stimulated by these encouraging observations an investigation of the therapeutic qualities of camphoric acid was instituted by Niesel, at the Royal University Hospital of Greifswald, under the guidance of Professor Mosler.

Niesel employed the drug in solution with alcohol and water, as advocated by Reichert, and also in solution with water and glycerine; and finally in an alkaline solution: three parts of bicarbonate of soda to four parts of camphoric acid being used. As the alkaline solution was not stable, but became mouldy, after being kept for any length of time, it was always prepared immediately before its use. The results obtained with the drug were eminently satisfactory.

The most recent experiments with camphoric acid were also conducted in Professor Mosler's clinic in Griefswald, and the results are reported by Dr. Bernhard Hartlieb, in the *Wiener Medicinische Presse*, February 23, 1890. The drug was used in cases of acute and chronic catarrh of the mucous membranes of the respiratory tract; in acute and chronic cystitis; and in the night-sweats accompanying phthisis.

In angina and catarrhal pharyngitis a one-half to one per cent. solution was used as a gargle, and later a solution in glycerine of the same strength was similarly employed. The drug gave great satisfaction, and was very much liked by the patients. After an extensive use in this class of affections, it was apparent that the acid was equal, although perhaps not superior to other known remedies for similar disorders. In laryngitis the same results were obtained. The solution was also used for inhalation in eighteen cases of chronic bronchitis and pulmonary tuberculosis. While no apparent improvement in the objective symptoms of the disease was apparent, the subjective conditions of the patients were greatly improved under its use. The patients, without exception, declared that after the inhalations breathing became much easier, deeper inspiration was possible, and the oppressive feeling in the chest was greatly relieved.

Excellent results were obtained with camphoric acid in the treatment of cystitis. The cases treated were both acute and chronic. Recovery resulted in the chronic cases in from three to six weeks. The acid was used in a one-half per cent. solution; the bladder being washed out with this twice a day. The injections were prepared and given as follows: Ten parts of a twenty per cent. alcoholic solution of camphoric acid were added to four hundred parts of lukewarm water. Of this two syringefuls were injected into the bladder, and allowed to be immediately discharged; a third syringeful of the solution was then injected and retained for about fifteen minutes. When pyelitis

existed in connection with cystitis, the drug was administered internally as well as locally. In cases of acute cystitis, where the injections produced considerable irritation, the acid was administered internally only; the dose employed was eight grains three times a day. The treatment proved very effective. It will be observed that the results obtained with camphoric acid in the treatment of cystitis, at the Griefswald clinic, were far more satisfactory than those reported by Fürbringer.

Finally, the acid was used in the treatment of the night-sweats incident to phthisis; and Fürbringer's conclusions regarding the drug's efficacy in this complaint were confirmed. The dose prescribed by Fürbringer was, however, found to be unnecessarily large. In most cases one fifteen-grain dose produced the desired result; in only a few stubborn cases thirty grains were required. The results obtained were eminently satisfactory. In a few cases the night-sweats did not entirely disappear, but were lessened to such an extent as to be no longer inconvenient to the patients.

It may be concluded that camphoric acid is relatively harmless. No gastric or intestinal irritation of any consequence was observed to follow its use. In one case of cystitis, fifteen-grain doses, administered three times a day, caused pain in the region of the kidney, which disappeared as soon as the use of the drug was discontinued. In two other cases of cystitis, when used as an injection, the drug caused a slight and but temporary swelling of the glans penis, which was speedily relieved by the application of lead-water. Still another patient vomited after taking a single dose of thirty grains of the acid; the same patient, however, was able later to take fifteen-grain doses without nausea. In the cases of phthisis in which the drug was employed, fifteen-grain doses were admirably borne; and in many instances this was increased to thirty grains without producing any but encouraging results.

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From the foregoing it is evident that in camphoric acid we have a valuable therapeutic agent and one well deserving of a place in works on therapeutics. Camphoric acid is no new drug; yet its properties have been unrecognized until but recently. An important lesson may be drawn from this fact: a lesson which aspiring medical investigators would do well to follow, namely, that it is as important to conscientiously study the properties of already known drugs as to endeavor to invent new ones. The love for novelty is natural, and in the medical profession there is rather a tendency to be too much attracted by the pretensions of new drugs and to forget the value of old ones. In our pharmacopœia there are a large number of officinal drugs, the exact therapeutic properties of which are but slightly known, and which offer encouraging fields for study. We are heartily in sympathy with the profession in Germany, in their encouragement of the investigation of the properties of old and sometimes neglected articles of the materia medica, and we heartily commend the one we have just been discussing to the attention of the readers of the REPORTER.

UNIQUE CÆSAREAN SECTION.

A Cæsarean section of unusual interest was performed in this city, April 27, by Dr. Charles P. Noble, at the Kensington Hospital for women.

One of the most interesting features of the case is the fact that it was the second time that the same woman underwent the operation. She had been delivered two years ago by Dr. Howard A. Kelly, by Cæsarean section, and was the first woman to recover after this operation in Philadelphia, since the celebrated case of Mrs. Reybold, who was operated upon by Prof. Gibbon, three generations ago.

As a result of the inflammatory conditions accompanying her first Cæsarean delivery, a utero-abdominal fistula resulted and has

never closed permanently. Through this fistula the liquor ammonii discharged and labor came on about the eighth month of pregnancy. This woman is the third in this country who has twice been the subject of Cæsarean section. The case is, perhaps, unique in the existence of a utero-abdominal fistula, complicating pregnancy. The operation just performed consumed one hour, the patient being put to bed without shock, and with a pulse of eighty-four. A feeble, premature, male infant was delivered, which lived four hours.

BOOK REVIEWS.

[Any book reviewed in these columns may be obtained upon receipt of price, from the office of the REPORTER.]

MODERN SCIENCE AND MODERN THOUGHT. With a supplemental chapter on Gladstone's "Dawn of Creation" and "Proem to Genesis," and on Drummond's "Natural Law in the Spiritual World." By S. LAING. Illustrated. 2 vols., paper cover, pp. 187. New York: The Humboldt Publishing Co. Price, 45 cents.

The success of this book in England has been such that a sixth edition was demanded within a month from the date of first publication. In it the principal results of Modern Science, and the revolutions they have effected in Modern Thought, are concisely presented, with a statement of the results of recent inquiries into the composition and constitution of the earth and of the universe into the nature and laws of matter, the development of organized and animated existences, the history of man, the myths of various races and the religions of various peoples, with discussions of the nature of force, motion, electricity, light and heat. Altogether it is a useful and instructive book and one well worth reading. Its cheap form is a special commendation.

LAPARO-HYSTEROPEXIE CONTRE LE PROLAPSUS UTERIN (NOUVEAU TRAITEMENT CHIRURGICAL DE LA CHUTE DE L'UTERUS). ANTERIOR ABDOMINAL FIXATION OF THE UTERUS. By PAUL DUMORET, Former Interne in Medicine and Surgery of the Paris Hospitals. Illustrated with eight wood-cuts. 8vo, pp. 168. Paris: Office of the *Progrès Médical*, 1889. Price, three francs, fifty centimes.

This thesis contains first a review of the operations hitherto performed for prolapse of the uterus, a criticism of their inadequacy to meet the requirements of the case, and then a description, illustrated with wood-cuts, of the comparatively new operation, fixation of the uterus to the anterior abdominal wall, as recommended by Terrier. The author objects to the term "ventro fixation," frequently used to define this operation, as an abominable combination. The operation of hysteropexy, he says, can be performed in

different ways: by fixing the uterine cornua to the abdominal wall (the procedure of Olshausen), by fixing to the wall the pedicle of an ovary (the procedure of John Phillips); or, finally, by fixing the anterior wall of the uterus to the edges of the incision into the abdomen (the procedure of F. Terrier).

Dumoret's own method of operating approximates closely to those of Lawson Tait, Hennig, Czerny, and especially Leopold, but differs from them in some details. In conclusion, the author says that surgical treatment of prolapse of the uterus is the only effective treatment, that hysteropexy is the preferable method and that while a serious, it is not a grave operation.

Dr. Howard A. Kelly's work in this line receives recognition and consideration, and he is, we believe, the only American writer mentioned. The thesis is an interesting contribution to the surgical treatment of prolapse of the uterus; it will be read with interest by those familiar with the subject.

LITERARY NOTES.

—A life of Dr. Ephraim McDowell, the father of ovariectomy, is about to appear. It is written by his granddaughter, Mrs. Mary Young Ridenbaugh.

—The J. B. Lippincott Company announces that the third volume of the *Cyclopedia of Diseases of Children* will be ready this week. The delay in its appearance has been due to the large number of manuscripts and the elaborate nature of the volume.

NOTES AND COMMENTS.

William F. Jenks Memorial Prize.

The second triennial prize, of four hundred and fifty dollars, under the deed of trust of Mrs. William F. Jenks, will be awarded to the author of the best essay on "The Symptomatology and Treatment of the Nervous Disorders following the Acute Infectious Diseases of Infancy and Childhood."

The conditions annexed by the founder of this prize are, that the "prize or award must always be for some subject connected with obstetrics, or the diseases of women, or the diseases of children;" and that "the trustees, under this deed for the time being, can, in their discretion, publish the successful essay, or any paper written upon any subject for which they may offer a reward, provided the income in their hands may, in their judgment, be sufficient for that purpose, and the essay or paper be considered by them worthy of publication. If published, the distribution of said essay shall be entirely under the control of said trustees. In case they do not publish the said essay

or paper, it shall be the property of the College of Physicians of Philadelphia."

The prize is open for competition to the whole world, but the essay must be the production of a single person. The essay, which must be written in the English language, or if in a foreign language, accompanied by an English translation, should be sent to the College of Physicians of Philadelphia, Pennsylvania, U. S. A., before January 1, 1892, addressed to Louis Starr, M. D., chairman of the William F. Jenks Prize Committee.

Each essay must be distinguished by a motto, and accompanied by a sealed envelope bearing the same motto and containing the name and address of the writer. No envelope will be opened except that which accompanies the successful essay.

The committee will return the unsuccessful essays if reclaimed by their respective writers, or their agents, within one year.

The committee reserves the right not to make an award if no essay submitted is considered worthy of the prize.

Treatment of Whooping-Cough.

Dr. J. F. Purdom, of Mitchellsburg, Ky., has an interesting article in the *American Practitioner and News*, April 12, 1889, in concluding which he says:

Owing to the fact that we are not able to abort pertussis, it occurs to me that the most rational line of treatment we can adopt is that which can be carried out in all cases with the greatest amount of convenience and safety of administration; provided we can obtain thereby favorable results equal to those derived from the use of more dangerous drugs, heroic treatment, or more troublesome forms of administration. And while I have no new remedy to offer in the treatment of the disease, I wish to give my experience with an old drug, the use of which has been and is yet based upon my idea of the pathology of whooping-cough.

The fact being established that pertussis is caused by a specific germ which confines itself to the nasal, throat and respiratory mucous membranes, has not changed in my opinion the fitness of the internal treatment which I have used during the past eight years. The drug which I employ is ergot. I find ergot mentioned by several writers, but the amount given and the frequency of the dose I have not seen stated, neither have

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When I have diagnosed the case I prescribe fl. ext. ergot, given in wine or brandy, if objected to in water, every two or four hours, according to the severity of the symptoms; to a child of three months, five-drop doses, and to older children in proportion to age; and, as the urgent symptoms abate, I lessen the dose or extend the time, but continue the ergot until the spasmodic cough has ceased. My confidence in the curative effect of ergot is so settled that I tell the parents that so sure as they give the medicine as directed they will find improvement in the spasmodic cough inside of seventy-two hours. As a palliative in the early stage, I give in conjunction with the ergot a simple cough mixture composed of equal parts syr. ipecac, syr. squills, camphorated tinc. opium, and aromatic spts. ammon., with double the part of syr. tolu; dose according to age, and repeated as necessary to relieve the tenacity of the mucus and give rest at night. I regard it necessary as far as possible to have proper ventilation of the living apartments, with out-door exercise when the weather will permit. The feet should be kept dry and the body clothed with flannel during the course of the disease at all seasons, except the hot months of summer.

With a good, generous diet, I recommend all such hygienic measures as would tend to promote vigorous health. As will be at once seen, I do not claim any specific action for ergot, but believe it relieves congestion of the vessels about the medulla oblongata; also constringing the vessels of the parts invaded by the micro-organism, making the soil less fertile and the tenacious secretions less abundant, thereby making the enemy's stay of shorter duration, and at the same time cutting off his avenues for producing complications by lessening reflex irritability.

I have treated one hundred and three cases of whooping-cough with ergot and a simple cough mixture, and without a death. I have had neither capillary bronchitis, pneumonia, nor convulsions to arise after treatment was begun. Neither has there been any hemorrhage worthy of note. The spasmodic cough has lasted from seven days to four weeks; and there has been seldom a tonic course of treatment required in the stage of decline, as a result of anemia or retarded convalescence.

Distemper in Dogs.

Although dogs enjoy the friendship of man far beyond any other animal, except perhaps the horse (and with elderly ladies the cat), their diseases have attracted very little attention, and when they fall ill they are left to the tender mercies of the nearest "vet." whose skill is by no means always on a par with his reputation. The subject of rabies, it is true, has been carefully inquired into, but the explanation of this departure from our usual indifference is to be found in the fact that human beings are liable to contract the disease, and the exception testifies to our egotism rather than to our humanity. One would have thought that a disease like distemper, which annually claims as its victims thousands of the young and beautiful of the canine race, would long ere this have been investigated and means devised for protecting our quadrupedal friends from the fate in store for them. We are pleased to record that at last this subject has found its Pasteur, and that the possibility of averting distemper now seems to be within measurable distance. Mr. Everitt Millais has carried out a series of bacteriological observations and experiments at the laboratory of St. Thomas's Hospital, the results of which, so far as they go, point to the practicability of affording an immunity against the disease by inoculation with a modified virus. Their number does not authorize any absolute conclusions, but the record is decidedly encouraging, and should pave the way to observations on a larger scale. Mr. Millais has proved, at any rate, that the malady is due to the presence of one or more micro-organisms, and the rest of his experiments were carried out on the lines which have yielded such brilliant results in respect of other diseases. — *Med. Press and Circular*, April 16, 1890.

Death from Pressure on the Fontanelle.

An old woman in Tranquility, near Easton, Pa., recently showed several children the fontanelle, or "soft-spot" on the head of a baby four months old. After the woman left the house the curiosity of the children became aroused, and all of them pressed down on the soft spot when they had a chance.

The story of one of the children was that every time she put her finger on the soft spot

the baby cried; that she did not know she was doing wrong. The infant was taken sick, inflammation of the brain set in, and death followed. The father had one of the self-accused children arrested, but the Prosecuting Attorney directed the complaint to be dismissed on the ground that if a crime had been committed the accused was not responsible for it.

Terpin Hydrate in Whooping-Cough.

In the *Wiener med. Presse*, March 23, 1890, it is reported that Dr. Wilhelm Manasse has had good results from the administration of terpin hydrate in cases of whooping-cough. He gave to children under one year old as much as twenty-two grains without any disturbance of the urinary or digestive apparatus. With doses of forty-five grains in twenty-four hours, no albumin or blood was found in the urine. Manasse used terpin hydrate in forty-one cases, the patients ranging in age from nine months to twelve years. In general he found an improvement in the patients, with diminution of frequency and severity in the spell of coughing, in four or five days after beginning to use the remedy, when the quantity varied from about twenty to about forty-five grains per day according to the age of the child.

Manasse calls special attention to the bronchial catarrh of whooping-cough and the influence of terpin hydrate upon it. He gave the drug in powder about seven and a-half grains to 15 grains three times a day.

NEWS.

—The Health Office of Jackson County, Mississippi, has reported a case of leprosy in that county. Steps have been taken by the State Board of Health of Mississippi to isolate the case.

—Professor W. W. Keen, M. D., has resigned the position of lecturer on art anatomy at the Academy of the Fine Arts of Philadelphia, and Dr. George McClellan has been chosen as his successor.

—Dr. G. Frank Lydston, of Chicago, has been invited to deliver the opening public address before the Kentucky State Medical Society May 14. His subject will be "Materialism vs. Sentiment in the Study of Crime."

—The sixth annual meeting of the National Conference of State Boards of Health

will be held at the Maxwell House, Nashville, on Monday, May 19, preceding the annual meeting of the American Medical Association.

—Dr. Samuel B. Swavely, whose expulsion from the Pottstown, Pa., Medical Society was recorded in the *REPORTER*, Sept. 28, 1889, was arrested in Pottstown, April 29, for criminal malpractice and held in \$700 bail.

—The annual dinner of the Medical Alumni of the University of Pennsylvania took place April 30. Speeches in response to toasts were made by Provost Pepper, Mr. Talcott Williams, and Drs. Mitchell, Keen, Billings and Wood.

—Dr. E. W. Pritchard, of Coldwater, Kansas, and an attorney, met at a muddy crossing on May 2, and became engaged in a quarrel as to whom should be given the most room to pass. Dr. Pritchard was finally thrown into the mud. Directly the men came to blows, which ended with the attorney hitting his opponent with a revolver, felling him to the ground. Dr. Pritchard died on Saturday afternoon.

—Dr. Ryland Brown died in Indianapolis May 2, at the age of eighty-three years. In 1858 he accepted the Chair of Natural Science in the Northwestern Christian University, in Indianapolis. During the last two years of that period he filled the Chair of Chemistry in the Indiana Medical College. In 1872 he was Chemist-in-Chief of the Agricultural Department at Washington. He was the author of a work on physiology, which was used as a text-book for many years in the schools of Indiana.

—At the last examination of the candidates for the position of residents at the Philadelphia Hospital the following physicians were appointed, after a competitive examination: Drs. William S. Carter, John H. Rhein, Frances S. Janney, Frances C. Van Gasken, Edwin P. Teuter, Samuel T. Buck, Nathaniel J. Dundelberger, Samuel P. Eagleton, Carl A. Hamann, Gregory H. Hoonanian, Frederick P. Reynolds, Henry N. Doan, Howard S. Anders, Daniel E. Morris, Charles S. Martin, James L. Ley, Thomas G. McConkey, Mrs. Esther L. B. Mathews, Joseph L. Nicholson and George M. Muttact. Thirteen of the successful candidates were graduates of the University of Pennsylvania; three of the Woman's Medical College; three of the Medico-Chirurgical College of Philadelphia, and one of the Jefferson Medical College.

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